5635 N. Scottsdale Rd., Scottsdale, AZ, 85250 Phone: (480) 261-4061 Fax: (480) 535-5548 Admin@IntuitivePsychologyPLC.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Legal Name____ DOB: ________________
Address: ____
City__________________________________State_________________Zip Code___________________
Home Phone#:________________________________Daytime Phone____________________________
Dates of Treatment______________________________________SS#___________________________
Purpose of Disclosure: _____Continuing Medical Care______Attorney Request_____Self ______Other

I hereby authorize Intuitive Psychology, PLC to _______release to the requestor and/or ______obtain the following medical records, including those which may contain confidential HIV/AIDS-related information, confidential communicable disease related information, and/or information relating to mental health and/or alcohol/drug use:

_____Initial Examination
_____Progress Notes
_____Lab Results
_____Psychological/Neuropsychological Reports
_____Consultations
_____Hospital Records
_____Imaging Results
_____Verbal Communication
_____Other:____

Requestor/Provider: ____
Address:____
City:___________________________________State:_______________Zip Code:________________
Telephone #: ________________________________Fax#:_____________________________________
Contact Person:____

I understand that I may revoke this authorization at any time, except to the extent that action, based on this authorization, has already been taken, by notifying Intuitive Psychology, PLC in writing. This consent will expire automatically on year from the date on which it was signed. Any disclosure of medical information by the recipient(s) is not authorized without specific consent of the patient, parent or legal guardian. I will allow information to be faxed if necessary.

____ _____________________
Signature of Patient Date

____ _____________________
Signature of Guardian or Authorized Person/Relationship Date