Intuitive Psychology, PLC
...behavioral medicine for body, mind and spirit

5635 N. Scottsdale Rd Suite 170, 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
_____Consultations
_____Progress Notes
_____Hospital Records
_____Lab Results
_____Imaging Results
_____Psychological/Neuropsychological Reports
_____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