Our Counseling Office

Authorization to Release PHI

This form, when completed and signed, authorizes the release or exchange Protected Health Information (PHI) from your clinical record to or with the person or agency you designate.

❐ 3040 e cactus rd suite a phoenix az 85032

❐ 8124 e cactus rd suite 410 scottsdale az 85260

602 494 1515

fax 602 494 3131

"creating opportunities for growth"

a group of independent behavioral health professionals

I Authorize my / our psychologist, Mark Rohde, Ph.D. to:

_______ **Release/Disclose** (initial) _______ **Exchange** (initial) _______ **Obtain** (initial)

The Following Information:

_______ outpatient treatment records, excluding billing information (not including psychotherapy notes)
initial

_______ relevant information via verbal, written, and / or electronic means
initial

_______ specify: ______________________________
initial

To Be Released To, Exchanged With or Obtained From:

____
Name of Person/Agency/Institution

____
Street Address

____
City State Zip

____
Phone Fax

For The Following Purpose: _______ (initial) for coordination of care

_______ (initial) at the request of the client

_______ (initial) specify: ______________________________

This authorization will remain in effect for 12 months or until discharged, whichever is later, or until the date identified here: _____/_____/______ .

I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Rohde at his business address. However, the revocation will not be effective to the extent that Dr. Rohde has already shared information based upon a prior authorization. I understand that Dr. Rohde generally may not condition the provision of services upon the signing of an authorization, unless the psychological services are provided for the purpose of creating health information for a third party (e.g., court order). I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and therefore may no longer be protected by the HIPAA Privacy Rule.

______________________ ______________________ ____/____/____
signature of client printed name of client date of birth

______________________ ______________________ ____/____/____
signature of representative printed name of representative date

If the authorization is signed by a *representative* of the client, a description of such representative's authority to act for the client must be provided here: ______________________________