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

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.

"creating opportunities for growth"

a group of independent behavioral health professionals

_____ _____ ____/____/____
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: _____