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.

I Authorize my / our psychologist, Gerald David Zirin, Psy.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 Exchanged With or Obtained From:

_____
Name of Person/Agency/Institution

_____
Street Address

_____
City State Zip

_____
Phone Fax

Dates of Service: _____

To Be Exchanged With or Released To: Gerald David Zirin, Psy.D. Clinical Psychologist
Fax To: 1(888) 839-1279
If additional correspondence is required: 602-363-2872; 2710 E. Emile Zola Ave, Phoenix, AZ 85032

For The Following Purpose:

_____ (initial) for coordination of care
_____ (initial) at the request of the client
_____ (initial) specify: _____

I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge). I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **G. David Zirin, Psy.D.**. **G. David Zirin, Psy.D.** will not be held liable for information disclosed to another party per the client's request.

This authorization will remain in effect for 12 months or until discharged from care. I understand that I have the right to revoke this authorization at any time by sending written notification to Dr. Zirin at his business address. However, the revocation will not be effective to the extent that Dr. Zirin has already shared information based upon a prior authorization.

_____ _____ / /
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: _____