

Authorization for Release of Confidential Information

Patient Name: _____ **Patient Soc. Security:** _____

I hereby authorize Tonya A. Thompson, P.O. Box 64747 Tucson, AZ 85728 (mailing address)
(doing business at 526 E. Roger St. Tucson, AZ 85705).

Phone # 520-271-4415

To release: _____ To receive: _____ confidential information (via mail, telephone and/or FAX) related to mental health treatment, and/or psychiatric/psychological treatment, including records of testing, medication, diagnosis, assessment, and insurance records as applicable, with the following organizations:

The extent or nature of information to be disclosed is:

- Psychiatric records: _____
- Personal assessment: _____
- Progress notes: _____
- Physical exam: _____
- Other (specify): _____

The purpose of, or need for, this disclosure is:

Continued care _____ Processing of insurance claim _____
Application for insurance _____ Other _____

Comply with this release automatically: _____

Comply with this release on request: _____

This authorization expires on _____ unless revoked by me in writing prior to that date. If I specify no date, the authorization will expire in one year. I understand that I may revoke my consent to allow release of this information, except to the extent that action has been taken on the information released prior to the revocation of my consent.

Patient Signature

Date

Witness

Date