R & R Psychiatric Care

2680 S Val Vista Dr, Building 15 Suite 185, Gilbert, AZ 85295
Office (480) 630-4434 Fax (480) 630-5285 www.rrwellness.org

Authorization for the Release of Client Information

Client Name: _____ DOB:_____ Phone Number:_____

Street Address: _____ City/State/Zip: _____

I, the undersigned, hereby AUTHORIZE:
R & R Psychiatric Care 2680 S Val Vista Dr Bldg 15 Ste 185, Gilbert AZ 85297
Phone: (480) 630-4434 Fax: (480) 630-5285

RELEASE OF INFORMATION

__ Release to __ Receive from __ Release AND Receive

Name of Provider or Organization: _____

Street Address: _____ City/State/Zip: _____

Phone: _____ Fax: _____

PURPOSE OF RELEASE: _____

INFORMATION TO BE RELEASED: (Please check next to each item of information to be released)
_____Psychiatric Evaluation _____Patient Care Summary _____Progress Notes _____Medications _____Alcohol/Drug Info
_____504 Accommodations/Chronic Health Condition letter ____Disability or FMLA Paperwork _____Tests or Lab Results
Other (Specify):_____

INFORMATION FOR INFORMED CONSENT

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Arizona Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of any health/hospital records or information, except as specifically provided for within the Statutes, Rules and Regulations.

This authorization for the Release of Medical Information waives all rights that the individual now has or in the future may have to bring any legal action against the releasing person/facility for any damages caused directly or indirectly by the release of this information or other confidential information. Upon request, the individual will be given a copy of the completed "Authorization for the Release of Client Information." You can revoke this consent at any time, except insofar as action has been taken in reliance on it (such as sharing records when still in effect). This authorization is effective immediately and will expire 60 days after closure of care and discharge from R & R Psychiatric Care.

_____ _____ _____
Signature of Client or Legal Guardian Printed Name Date

_____
Name of Client if a Minor