A New Path Psychotherapy Services, PLLC

4600 E. Shea Blvd. Suite 200

Phoenix, AZ 85028

(480) 200-0410

Authorization to Disclose Health Information

Client Name: _____

Health Record Number:_____

Date of Birth:_____ S.S. No.:_____

1. I authorize the use or disclosure of the above named individual's health information as described below:

2. The following individual or organization is authorized to make the disclosure:

A New Path Psychotherapy Services, PLLC
Molly Dean, LCSW
4600 E. Shea Blvd. Suite 200
Phoenix, AZ 85028
(480) 200-0410

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

___ Mental Health Records	___ Test Results	__ AIDS/HIV Related Information
___ Court/Legal Records	___ School Records	___Substance Abuse (drug/alcohol) Records
___ Consultations	___ Discharge Summary	___Medical Records (excluding HIV)
___ Verbal Information	___ Progress Notes	___Communicable Disease Information
___ Psychosocial History	___ Treatment Plan	__Crisis Assessments/Interventions
___ Psychiatric Evaluation	___ Other (Specify)	__ Entire chart

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This information may be disclosed to and used by the following individual or organization:

Name, Phone, Address of the Source to Which Information is to be Released

6. I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the end of the pending of my claim or lawsuit.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carriers with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

8. California/Arizona Restriction. I understand that a recipient of medical information in California or Arizona may not further disclose medical information about me (patient) unless a new Authorization form is signed by me or my personal representative or unless the disclosure is specifically required or permitted by law.

9. You are further authorized to discuss my case in detail with:_____or their representatives, and assist them in any way they may request your services.

10. I acknowledge receipt of a signed copy of this authorization____ (Initials)

11. This Authorization is good for one year at date of signing or until _____

Signature of Client or Legal Representative:

_____ Date:_____

If Signed by Legal Representative, Signature of Witness and Relationship to Client:

_____ Date: _____

A photocopy of this Authorization will be considered as an original. This Release complies with the HIPAA Privacy Rules.