Paradigm Psychiatry

Paradigm Psychiatry
2460 W Ray Rd., Bldg B, Suite 1
Chandler, Arizona, US - 85224-3556

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PARADIGM PSYCHIATRY

MAILING: 2460 W RAY RD SUITE1 CHANDLER, AZ 85224

OFFICE PHONE: 480-613-9599 FAX: 480-900-8515

Patient Name: *

Date of Birth: *

Address: *

SEND RECORDS TO/FROM

Name of Person of Facility: *

Address: *

Phone Number: *

Fax Number: *

Specific description of the information to be disclosed:

- ☐ Demographics
- ☐ Psychological Testing
- ☐ Medication Consent
- ☐ Phone Contact
- ☐ Psychiatric Evaluation
- ☐ Billing Reports
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ FULL MEDICAL RECORD

Specific Description of the purpose of the disclosure:

- ☐ Continued patient care
- ☐ Disclosure at patient request

I authorize the provider to use or disclose information related to:

- ☐ Behavioral Health Care/Psychiatric Care
- ☐ Insurance Coverage (COB)
- ☐ I consent to the release of information created within 12 months before/after the date this authorization was signed.

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I understand that the clinic will not condition treatment by signing this authorization. The clinic will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I understand that I may revoke this authorization at any time; unless the disclosing party has already relied on my authorization to disclose health information. To revoke this authorization, I must submit a written request to Paradigm Psychiatry. Unless I revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re-disclosed by this person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

PATIENT SIGNATURE * _____

If you are not the patient, but signing on behalf of the patient:

Print Name: _____

Relationship: _____

Parent/Legal Guardian Signature: _____