Authorization for Release of Confidential Information

Patient Name: ______________________________ **Patient Soc. Security:** ____________________

I hereby authorize Jeff Schultz, LPC or Francesca Schultz, LPC of the Sonoran Healing Center LLC, also doing business as Sonoran Counseling Services, 1130 E Missouri Ave, Suite 550, Phoenix, AZ 85014. Phone: 480-287-2393.

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 person or organization:

Name of Person or Organization____

The extent or nature of information to be disclosed is:

- Psychiatric records: __________
- Personal assessment: __________
- Progress notes: __________
- 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 no date is specified by me, 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