MindSource Centre
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Tucson, AZ 85715
Phone: 520-296-7766
Fax: 520-296-2301
Website: www.mindsourcecentre.com

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

An individual release of information must be filled out for each individual or organization that will be releasing or receiving you protected health information. A request for release request may be made in person, by mail, or by fax, unless otherwise stated.

Patient Name: ____ Date of Birth:_________________________

Social Security Number:_______________________________________

The above named patient or legal guardian herby authorized Stephen Streitfeld MD and staff of MindSource Centre to: [ ] Disclose to, [ ] Obtain from, or [ ] Exchange information with:

Person or Organization Name:____

Address: ____ City________________________ State:_________

Phone Number:_________________________________ Fax Number:_______________________________________

In addition to the general authorization to release records and health information, I authorize the release of records described as following:

1. [ ] YES [ ] NO Psychiatric/psychological information including diagnosis or treatment.
2. [ ] YES [ ] NO Addiction, substance abuse, or alcohol treatment.
3. [ ] YES [ ] NO Verbal communication between the MindSource Centre & above persons.
4. [ ] YES [ ] NO Sharing of communicable disease information, including records, testing, diagnosis, or treatment of HIV, HIV-related illness, AIDS, and AIDS-related illness.
5. [ ] YES [ ] NO Laboratory results, pathology slides, videotapes, photographs, X-Rays, or other diagnostic imaging results.
6. [ ] YES [ ] NO Billing or financial information.

Disclosure of this information is for the purpose of: [ ] Continuing Care, [ ] Change of Providers,

[ ] Legal Matter, [ ] School, [ ] Employment, [ ] Payment of Services,

[ ] Other:____

I understand that my records and health information are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Part 2, and cannot be disclosed without written consent unless otherwise provided for in the regulations. I also understand that this authorization is valid for one (1) year from the date signed and may be revoked by written notification at any time. I understand that I cannot retroactively revoke this authorization for information that has already been released. A photocopy of this authorization may be treated like the original. I understand the protected health information used or disclosed per this authorization may be subject to re-disclosure by the recipient and may no longer be protected.

The release of information will be accepted only if all items have been completed. Release of records or information may be subject to a charge.

_______________ ____ _________________________

Date Signature of Patient or Guardian Witness