Authorization to Release Medical Records

Patient Name: ______________________________ DOB: ______________________

Patient Address: ____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS:

To/From: Eat, Talk & Play Therapy LLC
3013 N. 67th Place Suite 101
Scottsdale, AZ 85251
Phone: 480.247.9190
Fax: 480.247.9718

To/From: ______________________
____
____
____
____

Please provide the following records requested/as requested: ______________________________
____

Date(s) of Service: ____

_____ Consultation Report _____ Medical Records _____ X-Ray/Radiology Reports
_____ Lab/Pathology Reports _____ Most Recent Doctor Notes
_____ Other: ____

By signing below, I hereby authorize the identified above to provide a copy of any and all medical records related to the care or services provided. This request shall include mental health records.

This authorization is valid for 6 months from the date of signing and may be revoked at any time by providing written notice. I understand I cannot revoke this authorization retroactively for any information already received.

I hereby release you, your physicians, and your employees form any and all liability for fulfilling the authorized request for release of medical information. I understand that a photocopy/fax of this authorization is considered acceptable in lieu of the original.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

______________________________________ ______________________
Parent/Guardian Signature Date

____
Parent/Guardian Name Printed