

ARIZONA FAMILY RESOURCE/COUNSELING CENTER

10000 N. 31ST Avenue

Suite A105

Phoenix, Arizona 85051

Phone – 602-843-0000 Fax- 602-997-1305

Record Release:

Re: _____ Date of Birth _____

Name of patient

I, _____, authorize Arizona Family Resource/Counseling

Center and _____ to release/obtain information:

To/From: _____

For the purpose of: _____

The information shall include all confidential HIV-related information, confidential communicable disease-related information, confidential alcohol or drug abuse-related information and confidential mental health diagnosis/treatment information. I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. In any event this consent will automatically expire on _____.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. A photo copy of this authorization will be considered as valid as the original.

Patient/Guardian Signature

Date

Witness

Date

This information has been disclosed to you from confidential records which are protected by state law that prohibits further disclosure of the information without the specific written consent of the person to whom it pertains or as otherwise permitted by law. A.R.S. Sec. 36-664(G). A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any of this information to criminally investigate or prosecute any alcohol or drug abuse patient.