PHOENIX RISING
INTERVENTION AND COURT ADVOCACY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I understand the information released may be subject to release by the person(s)/agency receiving it an no longer protected by the federal privacy regulations.

Client Name: _____ Date of Birth: _____

Address: _____ City: _____State: _____Zip: _____

I authorize Phoenix Rising Intervention and Court Advocacy Services to receive and/or release relevant case and or healthcare information of the client named above to:

Agency/Individual: _____

Address: _____City: _____State: _____ Zip: _____ Phone: _____

Fax: _____ Email: _____

Agency/Individual_____

Address: _____City: _____State: _____ Zip: _____ Phone: _____

Fax: _____ Email: _____

Agency/Individual_____

Address: _____City: _____State: _____ Zip: _____ Phone: _____

Fax: _____ Email: _____

For purposes of:

_____Clinical Assessment

_____Collaboration between Mental Health Providers and/or Medical Health Provider

_____Family Member/Payee of contracted services

_____Other_____

Information will be released by: _____Verbal _____Phone _____Written _____Unsecure Email _____Fax

This authorization for release of information is valid for one year from date of signature, unless rescinded by client at their discretion.

Signature: _____ Date: _____