AUTHORIZATION TO DISCLOSE INFORMATION

Dr. Melanie Bierenbaum

14354 N Frank Lloyd Wright Blvd, Bldg C, Ste 10, Scottsdale, AZ 85260

Patient Name _____

Date of Birth _____

Patient Address

_____

Street City State Zip

Patient/Guardian Phone Number

_____

I, the undersigned hereby authorize the sharing of the following Protected Health Information regarding the patient named above to the person or organization listed below.

I authorize Dr. Bierenbaum to provide and/or exchange information with the following individual(s) or organization:

_____

Individual's Name, Title & Organization

_____

Address City State Zip

_____

Telephone number, Fax number, and/or email address

I understand that the following items from my Protected Health Information will be shared:

☐ Progress Notes ☐Medical History

☐Psychosocial History ☐Admissions & Discharge Summaries

☐Treatment Plan & Summary ☐Recommendations

Other:_____

Preferred Means of Communication (Fax, Email, Phone, etc.): _____

1. I understand the purpose for sharing this information is for:

☐Treatment Collaboration ☐Case Consultation

☐Evaluation ☐Other: _____

2. I understand that I may refuse to sign this authorization and that Dr. Bierenbaum will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that this authorization is subject to revocation at any time in writing to Dr. Bierenbaum except to the extent that action has been taken based on my authorization; or obtained my authorization for the purpose of receiving reimbursement from a third party payer.

4. Unless previously revoked, this authorization shall expire on ____/____/____ (specific date) and one year for releases to persons providing on-going services to the patient such as school personnel, psychiatrists, pediatricians, etc.; or after the following event has occurred or condition has been met: _____.

_____ I DO NOT WISH TO HAVE ANY INFORMATION DISCLOSED TO OUTSIDE INDIVIDUALS OR ORGANIZATIONS

_____	_____	_____
Signature of Parent/Legal Guardian	**Printed Name**	**Date**
_____	_____	_____
Signature of Patient	**Printed Name**	**Date**
_____	_____	_____
Signature of Witness	**Printed Name**	**Date**