

Dr. Justin Jones, MD
Fax 866-831-1158
Tel 480-899-4077



Consent to Release Information

Date: _____

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I, _____, hereby authorize **The Arizona Schwartz Group, PC (Dr. Justin Jones, MD)** to:

___ (send) ___ (receive) the following information marked below ___ (to) ___ (from)

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

A SEPARATE AUTHORIZATION, AS DEFINED BY HIPAA, IS REQUIRED FOR *PSYCHOTHERAPY NOTES.

- | | |
|---|---|
| <input type="checkbox"/> Academic testing results | <input type="checkbox"/> Psychological testing results |
| <input type="checkbox"/> Behavior programs | <input type="checkbox"/> Service plans |
| <input type="checkbox"/> Progress reports | <input type="checkbox"/> Summary reports |
| <input type="checkbox"/> Intelligence testing results | <input type="checkbox"/> Vocational testing results |
| <input type="checkbox"/> Medical records/reports | <input type="checkbox"/> Entire record, except progress notes |
| <input type="checkbox"/> Personality profiles | <input type="checkbox"/> *Psychotherapy Notes |
| <input type="checkbox"/> Psychological reports | <input type="checkbox"/> Laboratory Tests |
| <input type="checkbox"/> Phone contact | <input type="checkbox"/> Behavioral and Emotional Scales |
| <input type="checkbox"/> All information, all charts, all communication | |
| <input type="checkbox"/> Other, specify _____ | |

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The above information will be used for the following purposes:

- Planning appropriate treatment or program
- Continuing appropriate treatment or program
- Determining eligibility for benefits or program
- Case review Updating files
- Other (specify) _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to client: Self Parent/legal guardian Personal representative
 Other (describe) _____

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Client's Signature: _____ Date: ____/____/____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: ____/____/____

Witness (if client is unable to sign)

Signature: _____ Date: ____/____/____

Physician Signature _____ Date: ____/____/____

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