SAN TAN COUNSELING

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Authorization to Request Personal and Confidential Information

The undersigned hereby authorizes and consents _____(Counselor) at *San Tan Counseling, 3740 E. Southern Ave, Mesa, AZ 85206* to request and receive the personal and confidential psychiatric, psychological, medical, therapeutic and academic information (written and/or oral) generated by the individual or institution identified below.

_____ _____ _____
(Name of person, party or agency) (Phone) (Fax)

_____
(Address/City/State/Zip Code)

RE: The continuing care of _____ _____
(Client/Patient Name) (Date of Birth)

_____ _____
(Address/City/State/Zip Code) (Phone)

I understand that my records are protected under various confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws. I certify that this request of information has been made freely, voluntarily and without coercion and the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except to the extent that action has already been taken to comply with it. This consent (unless expressly revoked earlier) expires 90 days from the date of signature unless I express revocation at an earlier date.

A photocopy of this authorization is as authentic as the original.

X_____ X_____ X_____
Signature of Self, Parent or Guardian Printed Name Date

X_____ X_____ X_____
Signature of Self, Parent or Guardian Printed Name Date