

[ROI] RELEASE OF INFORMATION AUTHORIZATION

Mailing Address: 2430 W Ray Rd Bldg H Ste 3 Chandler, AZ 85224 Ph(480)613-9599 Fax(480)900-8515

Patient Full Name: *

Patient Date of Birth: *

Patient Home Address: *

Authorization to Release/Obtain Medical Records and other (PHI) Protected Health Information TO/FROM:

Name of Individual or Facility: *

Address: *

Phone Number/Email : *

Fax Number: *

Specific description of the Protected Health Information requested: *

☐ COMPLETE MEDICAL RECORD- Includes All (PHI) Protected Health Information/All Dates of Service

☐ Treatment Plans
☐ Medication Records

☐ Demographics
☐ Progress Notes
☐ Psychiatric Evaluations

☐ Psychological Testing

☐ Psychotherapy Notes

☐ Billing Records

☐ Laboratory Reports

☐ Discharge Summaries

☐ Appointment History

☐ Mental Health / Psychiatric Records

☐ Substance Use Disorder Treatment Records

☐ HIV/AIDS-Related Info

☐ Genetic Testing Info

Purpose Of Disclosure: *

☐ Continuity of Care / Treatment

☐ Patient Request

I understand that signing this authorization is voluntary and is not required for treatment. I may revoke this authorization at any time in writing, except to the extent action has already been taken in reliance on it. Information disclosed under this authorization may no longer be protected by federal privacy laws and may be redisclosed by the recipient. This authorization expires one year from the date signed unless revoked earlier. I release Paradigm Psychiatry PLLC, its providers, employees, officers, directors, medical staff, and business associates from liability for disclosures made in accordance with this authorization. I have the right to receive a copy of this authorization.

Patient/Guardian Signature: *

Patient/Guardian Printed Name: *

Date: *
