SUSAN E. SCHWARTZ
Ph.D.

Authorization to disclose/obtain protected health information.

CLIENT NAME: _____ DATE OF BIRTH: _____

This authorization must be written, dated, and signed by the client or by a person authorized by law to give authorization. This authorization may be revoked at any time. If it is not revoked, the authorization will remain effective until one year following the date set forth below).

I authorize Susan E. Schwartz, Ph.D. to:

_____ OBTAIN my healthcare information from:

_____ PROVIDE my healthcare information to:

NAME/ORGANIZATION:

_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

Susan E. Schwartz, Ph.D.
3625 E. Denton Lane Paradise Valley, Arizona, USA 85253
602-508-8761/ text:602-369-7149 sesphd@cox.net www.susanschwartzphd.com

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Ph.D.

Dr. Susan E. Schwartz may obtain and/or provide the following health care information (initial all that apply). By initialing the spaces below, I specifically authorize the release of the following information:

_____ Diagnostic Assessments

_____ Number/Dates of Sessions

_____ Discharge Summary

_____ Treatment Summary/Impressions

_____ Medical History

_____ Drug and Alcohol Treatment Information _____ All Health Care Information*

_____ Billing

_____ In Case of Emergency

_____ Other (please specify) _____

*This may include records relating to communicable diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV), behavioral and/or mental health care, alcohol and/or drug abuse treatment, and genetic testing, if any such information exists.

This information may be communicated:

_____ Verbally Only

_____ Written Only

_____ Both Verbally and in Writing

The recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

Client or Authorized Representative Signature: _____

Date: _____

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