Provider Approval
Initials:_____
Date:_____

AUTHORIZATION TO REQUEST MEDICAL INFORMATION

_____ _____

Patient's Name **DOB**

I REQUEST AND AUTHORIZE THE FOLLOWING RELEASE OF INFORMATION:

INFORMATION TO BE RELEASED BY:	**INFORMATION TO BE RELEASED TO:**
_____ _____ _____ _____	**Linda T. Hirsch, Ph.D. LLC** **3131 E Clarendon Ave/ Ste. 106** **Phoenix, Arizona 85016** **(602) 956-5005 Fax (602) 956-7638**

Phone: ( )_____ Fax: ( )_____
My initials and signature below authorize the release of health care information relating to testing diagnosis, and treatment for:

_____ **Complete Health History**

_____ **LABS**

_____ **Test Results**

_____ **Office Notes**

_____ **Conversation regarding this Mutual Patient**
THE ABOVE INFORMATION WILL BE USED FOR FURTHER TREATMENT OF CARE

I expressly and voluntarily authorize disclosure of the above medical record(s) for the purpose(s) stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent action has been taken on this authorization. I understand that I do not have a sign this authorization in order to get health care benefit (treatment, payment, enrollment, or eligibility for benefits) except if I receive healthcare when the sole purpose of the healthcare is to create health information for a third party.

I understand that once this health information has been disclosed, the recipient may re-disclose it in some situations. Privacy laws may no longer protect the information. I understand that this authorization does not permit the release of information does not extend to insurance companies.

This authorization expires_____(state date or event). Authorization will expire in 90 days if not otherwise specified.

X_____ DATE:_____
Authorizing Signature