10184 W. Happy Valley Rd. Suite 190
Peoria, AZ 85383

Phone 623.824.5051
Fax 623.889.9000

RECORDS REQUEST
AUTHORIZATION for RELEASE of CONFIDENTIAL INFORMATION

Patient: _____ Date of Birth: _____

Address: _____

Phone: _____

I hereby consent and authorize the release of the following information:

_____ Assessment results

_____ Report of findings

_____ Diagnostic information

_____ Summary of clinical sessions

_____ Any and all information necessary to assist with treatment planning and care

Information to be released BY:

The Serin Center
10184 W. Happy Valley Rd. Suite 190
Peoria, AZ 85383
Phone: 623-824-5051
Fax: 623-889-9000

Information to be released TO:

_____
Entity

_____
Address

_____
City State Zip Code

_____
Phone Fax

I understand that I may revoke this authorization in writing. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I hereby release Dr. Serin and/or her staff sending and/or communicating the records and results from any liability associated with the release of information. I understand this release will expire twelve (12) months from date of signature unless specified here _____.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent or Legal Guardian (Minor) Date

10184 W. Happy Valley Rd. Suite 190
Peoria, AZ 85383

Phone 623.824.5051
Fax 623.889.9000

RECORDS REQUEST
AUTHORIZATION for RELEASE of CONFIDENTIAL INFORMATION

Patient: _____ Date of Birth: _____

Address: _____

Phone: _____

I hereby consent and authorize the release of the following information:

_____ Assessment results

_____ Report of findings

_____ Diagnostic information

_____ Summary of clinical sessions

_____ Any and all information necessary to assist with treatment planning and care

Information to be released BY:

_____
Entity

_____
Address

_____
City State Zip Code

_____
Phone Fax

Information to be released TO:

The Serin Center
10184 W. Happy Valley Rd. Suite 190
Peoria, AZ 85383
Phone: 623-824-5051
Fax: 623-889-9000

I understand that I may revoke this authorization in writing. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I hereby release Dr. Serin and/or her staff receiving and/or communicating the records and results from any liability associated with the release of information. I understand this release will expire twelve (12) months from date of signature unless specified here _____.

_____ _____
Patient Signature Date

_____ _____
Signature of Parent or Legal Guardian (Minor) Date