



# Deer Valley Counseling

"Skills for Better Living"

## Authorization for Release of Confidential Information To Deer Valley Counseling

I, \_\_\_\_\_ Date of Birth of Client: \_\_\_\_\_  
(Client's Name or Person Authorized to Sign for Client)

hereby authorize \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

to release information to Deer Valley Counseling, 2301 W Dunlap Ave, Suite 206, Phoenix AZ 85021,  
Phone: 602.750.8051, Facsimile: 602.674.5701.

I understand that the purpose of the disclosure is to provide Deer Valley Counseling with information to aid in my ongoing treatment. The information to be disclosed includes –

- All health records
- Other: \_\_\_\_\_
- All mental health records
- Drug/alcohol information
- Test results

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I may revoke, in writing, this authorization at any time, except to the extent that action has already been taken in reliance on it. I understand that this information may be redisclosed by the recipient and at that time would no longer be protected by the originator. I understand that my healthcare provider may not condition services upon my signing this authorization unless the services are provided to me for the purpose of creating health information for a third party. This authorization for release of information will expire on

\_\_\_\_\_ (if left blank, one year from the date it was signed).

Printed name of Client	Signature of Client	Date Signed
Person Authorized to Sign for Client	Signature of Person Authorized to Sign	Date Signed

Reason person may sign for client:  Parent  Guardian  Other: \_\_\_\_\_