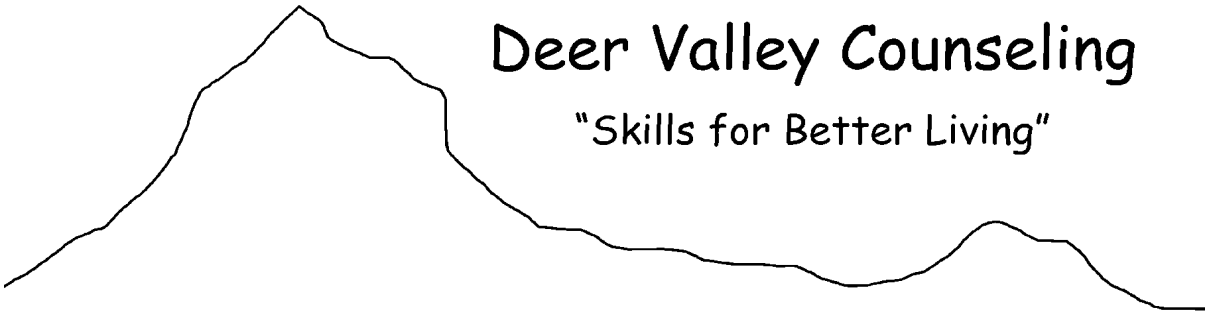

Authorization for Release of Confidential Information To Deer Valley Counseling

Client Name: _____ Date of Birth: _____

I 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.

*Something **must** be checked or written in this box.*

The information to be disclosed includes –

☐ All health records including alcohol and drug abuse evaluation and treatment information

☐ Other _____

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 the person or organization releasing this information 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: _____