the mandel center

**The Mandel Center of Arizona. LLC**
8120 East Cactus Road | Suite 310
Scottsdale, AZ 85260
Office: 480.734.1199
Fax: 480.551.3363
www.mandelcenter.com

# Authorization To Disclose Health Information, Page 1

**I, _____ whose Date of Birth is _____,**
**authorize The Mandel Center of Arizona to disclose to and/or obtain from:**
**_____ the following information:**

**DESCRIPTION OF INFORMATION TO BE DISCLOSED**

*(Client should initial each item to be disclosed)*

**_____ Assessment**
**_____ Diagnosis**
**_____ Psychosocial Evaluation**
**_____ Psychological Evaluation**
**_____ Psychiatric Evaluation**
**_____ Treatment Plan or Summary**
**_____ Current Treatment Update**
**_____ Medication Management Information**
**_____ Presence/Participation in Treatment**
**_____Nursing/Medical Information**

**_____ Educational Information**
**_____ Discharge/Transfer Summary**
**_____ Continuing Care Plan**
**_____ Progress in Treatment**
**_____ Demographic Information**
**_____Psychotherapy Notes***
**_____Other_____**
**_____Other_____**

*(*Cannot be combined with any other disclosure)*

**PURPOSE**

**The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.**

**If the purpose is other than marketing, sale of information, research or as specified above, please specify:**

_____

_____

**MARKETING**

❑ **If the purpose of this disclosure is for marketing purposes, please check this box and set forth the financial remuneration amount received by the The Mandel Center of Arizona in exchange for disclosing the information. $_____**

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# Authorization To Disclose Health Information, Page 2

**SALE OF INFORMATION**

❑ **If the purpose of this disclosure is for the sale, license to use or lease of the information, please check this box.**

**RESEARCH**

❑ **If the purpose of this disclosure is for research purposes, please check this box and identify the current and future research studies as well as whether each research study is conditioned upon execution of this authorization and individual's ability to opt into each study.**

_____.

**REVOCATION**

**I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to The Mandel Center of Arizona at 8120 E. Cactus Rd., Suite 310, Scottsdale, Arizona 85260. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.**

**EXPIRATION**

**Unless sooner revoked, this authorization expires on the following date:** _____
**or as otherwise indicated:** _____

**CONDITIONS**

**I further understand that The Mandel Center of Arizona will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences:** _____

_____

_____

_____

*[Insert an explanation of the consequences, if any, of not signing this authorization, which will depend on the services being provided].*

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# Authorization To Disclose Health Information, Page 3

**FORM OF DISCLOSURE**

**Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.**

**REDISCLOSURE**

**I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.**

**I will be given a copy of this authorization for my records.**

_____ _____

**Signature of Client** **Date**

_____ _____

**Signature of Parent, Guardian or Personal Representative** **Date**

**If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).**

_____

_____

❑ **Check here if patient/client refuses to sign authorization**

_____ _____

**Signature of Staff Witness** **Date**