Child, Adolescent, and Adult
Psychotherapy and Medication Management

Authorization for Exchange of Information

Name: _____Date of Birth: ____/____/____

Address: _____SS#:____/____/____

I hereby authorize Axon Health Associates, LLC
[ ] to release [ ] to obtain

Records to/from:

_____
Name Company

_____
Address Phone# Fax#

I request the following information to be released regarding myself and/or my child:
[ ] Initial Assessment and Treatment Plan [ ] Progress Notes
[ ] Psychological Evaluation [ ] Psychiatric Evaluation
[ ] Diagnosis [ ] Discharge Summary [ ] Other: [ ] Verbal [ ] Written

Indicate specific information to be EXCLUDED from this authorization (check all that apply):
[ ]Drug and Alcohol Records [ ] HIV/AIDS Records [ ] Infectious Disease records

The purpose for use or disclosure of information:
[ ] Continuity of Care [ ] Coordination of Services
[ ] Other: please provide a specific description of the purpose /use for disclosure:
_____

I understand that my records are protected under the Federal Confidentiality Regulation (42 CFR Part 2) and cannot be released or re-released without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time, except to the extent that release has already occurred.

This consent is valid for 90 days from the date signed by the patient or authorized party below, unless revoked by me prior to that date, upon the completion or satisfaction of the event or conditions specified; whichever comes first. A copy of this authorization shall be valid as the original.

I understand that the following fees may apply:
Record Retrieval $25.00
Charge $.25 (per page over 10 pages)
1-2 Day Service $10.00

Patient/Guardian Signature: _____Date:_____

_____ _____
Patient/Guardian Printed Name Witness Signature

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