



3110 N Swan Road, Tucson, AZ 85712  
Phone: 520-780-8413 \*\*\* Fax: 520-800-413

### Tucson Outpatient Psychiatry Release of Information

\_\_\_\_\_  
(Print Patient's Full Name)

\_\_\_\_\_  
DOB

I am requesting that a copy of my treatment records FROM:

Provider/Medical Facility:

Address:

Phone:

Fax:

are SENT to Tucson Outpatient Psychiatry Provider/s:

- Dr. Kristine Norris       Dr. Victoria Canelos       Dr. Betsy Myers       Dr. Chandan Nayak
- Dr. Cleve Shirey       Dr. Yue Zong       Dr. Cristel Alcocer       Aecha Guerrero
- Audrey Cione       Holly Randle       Ingrid Hall-Bidegain       Jarret Rosenblatt
- Jessica Olivas       Shira Klayman

This request is for:  Continuity of Care    Transfer of Care    Evaluation    Other

Date/s

Requested:

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will expire ONE (1) year from the date of signature unless I withdraw my consent. I understand that the records released may contain information pertaining to Psychiatric Treatment, including Substance Use Treatment. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits recipients of these records from making any further disclosures to third parties without the express written consent of the patient.

Printed Name of Patient:

Patient Signature and Date:

Printed Name of Guardian/POA:

Signature of Guardian/POA and Date: