Tucson Outpatient Psychiatry

3110 N Swan Rd
Tucson, AZ 85712
Phone: 520-780-8413
Fax: 520-800-8413

Authorization to Release/Receive Confidential Information

I _____ authorize __Tucson Outpatient Psychiatry___to:
Patient Name

Patient DOB: _____

☐ **Receive** my medical/therapy records from the following healthcare professionals:

(name, address) _____

(name, address) _____

☐ **Release** my medical records to the following healthcare professionals:

(name, address) _____

(name, address) _____

This information is for the following purposes:

_____

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 five (5) years 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.

_____. _____
Patient Signature Date