Tucson Outpatient Psychiatry

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

Tucson Outpatient Psychiatry Release of Information

_____ _____
(Print Patient's Full Name) **DOB**

I am requesting that a copy of my Records <u>FROM</u>:

Provider/Medical Facility: _____

Address: _____

Phone: _____ Fax: _____

are <u>SENT</u> 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 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.

_____
Printed Name of Guardian/POA

_____ _____
Patient Signature and Date **Signature of Guardian/POA and Date**