Janice Motoike, Ph.D., P.L.L.C.

Authorization Form for Release of Information

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate: I hereby give authorization to **Janice Motoike, Ph.D.** to release copies and/or discuss any or all information pertaining to my outpatient psychological treatment to the individual identified below. This may include confidential information related to alcohol or drug-abuse, communicable disease, sexually transmitted disease, AIDS/HIV (in accordance with AZ Statutes and Arizona or Federal Administrative Rules and Regulations); and psychological, behavioral health, educational, or other professional or non-professional service or data available. Information may be transferred verbally, by mail, or by fax at the discretion of the physician named below.

Patient Name:	DOB:
Address:	
Phone:	

- ☐ Information to schedule/cancel/reschedule appointments
- ☐ Copy of intake evaluation, including PHI
- ☐ Diagnosis
- ☐ Copies of progress notes
- ☐ Copy of entire record
- ☐ Other (Please describe):

This information is to be released to:

Name:	
Name of Agency:	
Address:	
Phone:	FAX:

I am requesting my psychologist to release this information for the following reasons:

- ☐ Scheduling/canceling/rescheduling appointments
- ☐ Consultation and/or coordination of care
- ☐ At the request of the individual
- ☐ Other (Please describe):

This authorization shall remain in effect until _____
Expiration Date or event/purpose of use/disclosure

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule

_____ _____
Signature of Patient Date

_____ _____
Signature of Guardian (if applicable) Date
If authorization is signed by representative of patient, evidence of representative's authority to act for patient must be provided

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