Janice Motoike, Ph.D. P.L.L.C.
Request for Records: Authorization Form for Release Of Information

This form when completed and signed by you, authorizes the identified individual to release protected information from your clinical record: I hereby give authorization to you to release copies and/or discuss any or all information pertaining to my outpatient/inpatient psychiatric or medical treatment to Dr. Janice Motoike, as indicated 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.

1.

Name of Patient:	Date of Birth:
Address:	Telephone:

2.

This information is to be released FROM:	**This information is to be released TO:**
Name of Person/Organization/Facility Janice Motoike, Ph.D. Janice Motoike, Ph.D. P.L.L.C.	Name of Person/Organization/Facility
Address 1955 W Baseline Rd Ste 113-520	Address
City/State Mesa, AZ 85202-9016	City/State
Telephone Fax: (480) 313-3080 (888) 972-8488	Telephone Fax:

3. **The purpose or need for this release is (✓ box):**

☐ Consultation and/or coordination of care ☐ At the request of the individual ☐ Other (Specify below)

4. **The information to be released from my records: *(✓appropriate box(es))***

- ☐ Entire Record (including administrative and billing records)
- ☐ Entire Clinical Record
- ☐ Only information related to (Specify) _____
- ☐ Only the period from: _____ to:_____
- ☒ Intake evaluation / psychiatric diagnostic interview
- ☒ Diagnosis
- ☐ Psychological evaluation
- ☐ Treatment summary via telephone.
- ☐ Other (Specify) _____

I understand that I may revoke this authorization in writing submitted at any time to the Health Records Department, except to the extent that action has been taken in reliance on this authorization, this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, or other law provides the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event as identified here: _____.

I understand that information released by this authorization may be subject to re-release by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule of 1996 and the Privacy Act of 1974.

Signature of Patient, Guardian, or Legal Representative ***(State relationship to patient if applicable)***	**Date**