480.331.5002 www.excelsocialservices.com

Authorization to use/disclose information

Name of client (to use/share information about): ____________________________________

Date of Birth: _______________________________

Name/Address/Telephone Number of Organization/Person to release information:

Excel Social Services Inc. at 4700 S. Mill Avenue Suite B3, Tempe, Az 85282 in the Mill Avenue Plaza

Name of Organization/Person to receive information: _________________________________

Address of Organization/Person to receive information: _________________________________

City: ________________________ State: __________________ Zip code: __________________

Telephone Number of Organization/Person to receive information: _____________________

The information to be use/disclosed for the following purpose:

____

(Please initial each line below)

________ I understand that this authorization can be revoked by me at any time by submitting a written request to **Excel Social Services Inc.**

_______ I understand that if the information has already been released, I will be unable to revoke my request.

_______ I understand that this release of information is valid for one year from the date signed below or when treatment is complete if within the one-year period.

_______ I understand that my records are protected under the Federal Confidentiality Regulations and cannot be released or disclosed without my written permission unless otherwise provided for in the law.

_______ I understand that if the above agency/individual is not a health care provider or health insurer, the information may no longer be protected by federal privacy regulations and may be subject to re-disclosure.

_______ I understand that I do not have to sign this authorization and that my refusal to do so will not affect my ability to obtain treatment/services from this agency nor affect my eligibility for benefits.

Information to be released:

☐ Progress Notes ☐ Treatment plans ☐ Intakes/Assessments

☐ Medical/Psychiatric Records/Information ☐ Billing Records ☐ Substance Abuse

☐ Hospitalization Records ☐ Verbal Information pertaining to: ____________________

☐ Other: ____

By signing below, I authorize Excel Social Services Inc. to release and exchange information with the person and/or agency listed above and affirm that everything in this form was clear to me and has been explained.

☐ _______ (client initials) **I acknowledge I received a copy of this form**

Client's Printed Name: ________________________________

Client's Signature: ___________________________________ Date: ____________

Parent/Legal Guardian Name: ______________________________

Parent/Legal Guardian Signature: ___________________________ Date: ____________

Clinician's Printed Name: ________________________________ Date: _____________

Clinician's Signature: _________________________________ Date: _____________

(If applicable, i.e., couple/family therapy)

Client's Printed Name: ________________________________

Client's Signature: ____________________________________ Date: ____________

Clinician's Printed Name: _______________________________

Clinician's Signature: _________________________________ Date: ____________