touchstone health services
partnering with families

AUTHORIZATION FOR RELEASE OF INFORMATION

PLEASE PRINT CLEARLY AND COMPLETE ALL FIELDS
PICK-UP RELASE AVAILABLE AT 15648 N. 35THE AVE PHOENIX, AZ 85053

_____	_____	_____	_____
Member's Name	**CIS #**	**AHCCCS #**	**Date of Birth**

Person/Agency authorized to make the disclosure: **Touchstone Health Services**
15648 North 35th Avenue, Phoenix, AZ 85053

Person/Agency Receiving the Information (must include name and address to process request):

Name: _____ **Phone #:**_____

Address:_____

E-mail: _____ **Fax #:**_____

****Please note if records are too large to e-mail or fax, records will be mailed in place.**

Preferred Release Method: ____ **Mail** ____ **Pick- Up** ____ **Fax** ____ **E-Mail**

Information to be disclosed, check all that apply:

☐ **Intake Assessment/Annual Assessments**	☐ **Integrated Care**	☐ **Progress Notes**
☐ **Med Monitor/ Dr. Consults**	☐ **Test Results/Labs**	☐ **COC (Coordination of Care)**
☐ **Psychiatric Assessments/Evaluations**	☐ **Case Management**	☐ **Verbal Communication**
☐ **Treatment/Service Plans**	☐ **Itemized Billing Statement**	☐ **Other (Specify Below)**

Other Information to Include:_____

Dates of Records: From: _____ **to:** _____**OR, if no dates, 2 years will be released.**

☐ Check here if each of the above parties may disclose your information with the other party. The above information may include records of drug abuse, alcoholism, sickle cell anemia, human immunodeficiency virus (HIV).

Purpose for Disclosure:_____

I understand I may revoke this authorization at any time by writing to the agency or marking and signing the appropriate box in the original signed copy of this form located in my medical record. The revocation will be effective except to the extent that action based on this authorization has already been taken. The agency may not condition treatment, payment, enrollment or eligibility for benefits on whether the consumer signs the authorization. The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.

***This consent will expire 1 Year from the date of Signature:**_____ **(Initial Here)**

OR: I revoke this authorization ON: Date:_____**Initial Here:**_____

_____	_____
Signature of Service Member/Guardian	**Date of Signature**
_____	_____
Other required signature (if applicable)	**Staff Member Reviewing & Submitting ROI**
_____	
Relationship to Service Member	

***If a consumer is between 12-18 years of age, both his/her signature is preferred along with the required signature of parent/legal guardian**