Donaghy Psychology & Consulting
10245 E Via Linda Ave, Ste 220
Scottsdale, AZ 85258-5317
(480) 668-3474 Ph (480) 668-3475 Fax

Authorization for Mutual Release of Information

I, _____, hereby authorize Dr. Kathleen Donaghy in the use and release of my individually identifiable health information as described below. I understand that this authorization is voluntary and that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy.

Patient Name _____

Address _____

Date of Birth _____ Social Security # _____

The following information may be released or received:

Treatment dates: _____ Hospitalization dates: _____

- Entire record
- Discharge summary
- History & Physical
- Lab results
- Medications
- Drug Screen
- Progress Notes
- Assessments
- Treatment plan
- Inpt. Hospitalization
- Emergency room
- Psychological testing
- School attendance
- Education assessment
- Other

The above information may be released to or received from:

Name/organization: _____

Address/Fax: _____

I, patient and/or guardian, have voluntarily authorized release of information as indicated above and understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I have the right to refuse this authorization. If I approve, the facility named above is release from all legal liability that may arise from the release of the information requested.

This consent will expire in one year after the date signed. I may revoke this authorization at any time providing I notify Kathleen B. Donaghy, PhD., in writing to that effect. However, such revocation will have no effect on any action taken previous to the physical receipt of such notice.

I agree to pay any copying charges incurred in preparing and delivering the information requested.

_____ _____ _____
Patient, Parent, or Guardian Relationship Date

_____
Witness