

Gregory M. Crow, Ph.D.
Psychologist

INSTRUCTIONS

7510 East Angus Drive
Scottsdale, AZ 85251
480-947-1989
Appts 623-572-4128
Fax 480-621-4105

AUTHORIZATION FOR INFORMATION RELEASE

TO: NAME OF PERSON(S) WHOM YOU WOULD LIKE DR. CROW TO SPEAK WITH
COUNSELOR, AGENCY, DOCTOR OR HOSPITAL

PHONE NUMBER OF ABOVE MENTIONED PERSON(S)

ADDRESS

PHONE

RE: YOUR NAME DOB: YOUR DATE OF BIRTH

I authorize Dr. Crow and the agency or individual stated above to discuss and/or exchange information and/or reports as initialed below. It is understood that this release is granted to assist the staff at each agency/office. It is further understood that this information once obtained, it will not be released to any other agency or individual.

INITIAL ON LINE(S) BELOW

_____ Social history/intake

_____ Treatment notes

_____ Psychological exam

_____ Hospitalization records

_____ Thank you for referral letter

_____ Testing results

YOUR INITIALS

ON THIS LINE

Other (Specify) **WRITE IN: Any of Above**

I understand that me 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 also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

NAME PRINT YOUR NAME

ADDRESS PRINT YOUR CURRENT ADDRESS

SIGNATURE YOUR SIGNATURE DATE DATE YOU SIGN
(PARENT/GUARDIAN IF MINOR)

WITNESS _____ DATE _____
(IF RELATIVE, STATE RELATIONSHIP)

Gregory M. Crow, Ph.D.
Psychologist

7510 East Angus Drive
Scottsdale, AZ 85251
480-947-1989
Appts 623-572-4128
Fax 480-621-4105

AUTHORIZATION FOR INFORMATION RELEASE

TO: _____
COUNSELOR, AGENCY, DOCTOR OR HOSPITAL

ADDRESS PHONE

RE: _____ DOB: _____

I authorize Dr. Crow and the agency or individual stated above to discuss and/or exchange information and/or reports as initialed below. It is understood that this release is granted to assist the staff at each agency/office. It is further understood that this information once obtained, it will not be released to any other agency or individual.

INITIAL ON LINE(S) BELOW

_____ Social history/intake	_____ Treatment notes
_____ Psychological exam	_____ Hospitalization records
_____ Thank-you for referral letter	_____ Testing results
_____ Other (Specify) _____	

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 also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon. **This consent (unless revoked earlier) expires one year subsequent to the signing of this release.**

NAME _____

ADDRESS _____

SIGNATURE _____ DATE _____
(PARENT/GUARDIAN IF MINOR)

WITNESS _____ DATE _____
(IF RELATIVE, STATE RELATIONSHIP)