Gregory M. Crow, Ph.D.
Psychologist

7510 East Angus Drive
Scottsdale, AZ 85251
480-947-1989
Appts 623-572-4128
Fax 480-941-0280

INSTRUCTIONS

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
_____ Psychological exam
_____ Thank you for referral letter
_____ Treatment notes
_____ Hospitalization records
_____ 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)

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