Gregory M. Crow, Ph.D.
Psychologist

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

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

_____ Psychological exam

_____ Thank-you for referral letter

_____ Other (Specify) _____

_____ Treatment notes

_____ Hospitalization records

_____ Testing results

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)

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Psychologist

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 MONTIONED 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.

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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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AUTHORIZATION FOR INFORMATION RELEASE

RE: _____ DOB: _____

I authorize Dr. Crow's office and the individual(s) stated below to discuss and/or exchange information as initialed below. It is understood that this release is granted to assist the staff with appointment scheduling for couples and financial arrangements. It is understood the authorization to schedule appointments applies solely to couple's appointments where both parties are expected to be present. It is further understood that information regarding individual appointments will remain confidential.

INITIAL BELOW

_____ Couple's Appointment(s)

_____ Billing Information

_____ Insurance Information (if applicable)

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____
_____	_____

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 (PRINT) _____

ADDRESS _____

SIGNATURE _____DATE_____
(CLIENT/PARENT/GUARDIAN IF MINOR)

WITNESS _____DATE_____
(IF RELATIVE, STATE RELATIONSHIP)