3404 W. Cheryl Dr.
Suite A150
Phoenix, AZ 85051

Authorization to release/exchange confidential information

This form cannot be used for the re-release of confidential information provided by other individuals or agencies. Such requests should be referred to the original individual or agency. I understand that My Buoyant Health will provide records but not participate in any legal matters regarding the patient's care without prior approval. This includes but is not limited to family court, child custody, drug or alcohol diversion.

I authorize My Buoyant Health to communicate with {Name, address, phone number, fax}:
_____ release to:
_____ obtain from:
_____ exchange with:
The following information pertaining to myself:
__ treatment summary
__ substance abuse treatment information
__ psychiatric evaluation/medication history
__ Other (please specify) _____

For the purpose of:
__ evaluation/ assessment and/or coordinating treatment efforts
__ other (please specify)

The consent will automatically expire one (1) year after the date of my signature and I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____
Signature of client Date