Adolescent Substance Abuse Program

2530 S. Alma School Road, Mesa, 85210
8607 N. 59th Avenue, Suite #C-6, Glendale, 85302
3839 E. Shea Boulevard, Phoenix, 85028
Phone (602) 434-0249 for all locations fax (480) 704-5550 see us online at www.asapaz.com

Authorization to Release Protected Health Information (PHI)

Under Arizona law, health information may be shared with your teen's current health care providers for the purpose of providing the best diagnosis and treatment. It is often helpful to share clinical information about your teen's diagnosis and treatment so that each professional organization can provide optimal care. This form authorizes ASAP staff to release or exchange Protected Health Information (PHI) from your teen's clinical record with the person you designate.

INSTRUCTIONS FOR PARENTS: If you would like us to coordinate care with your teen's health care providers by sharing personal and confidential information about his/her care, simply check the appropriate boxes, identify the professionals involved in treatment, and just sign and date:

I instruct ASAP staff to provide my teen's behavioral health diagnosis, treatment and other clinical information to:

- ❑ my teen's Primary Care Provider _____
  name
- ❑ my teen's psychiatric/counseling provider _____
  name
- ❑ other individual _____
  name

I also allow other health providers to provide information to ASAP staff in return about health issues that may have a bearing on my teen's treatment.

OR ❑ I would prefer that no information regarding my teen's behavioral health diagnosis, treatment, and other clinical information be shared with his/her primary care provider or psychiatric provider

Patient name _____ dob _____

Parent / Legal Guardian signature _____ date _____

NOTES: This authorization shall remain in effect until one year following the completion of treatment. I understand that I have the right to revoke this authorization at any time by sending written notification to ASAP. However, the revocation will not be effective to the extent that either party has already taken action in reliance on this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of this information and therefore may no longer be protected by the HIPAA Privacy Rule.