Q Counseling Services, LLC
301 E. Bethany Home Rd, suite C-296
Phoenix, AZ 85012
Tel. 602.570.2373, Fax 602.264.1887

HIPAA AUTHORIZATION FOR INFORMATION FORM

I, _____, (hereinafter "Patient") hereby authorize

Dr. Michael D. Peck and Q Counseling Services
301 E Bethany Home Rd, C-296
Phoenix, AZ 85012
Tel: 602.570.2373
Fax: 602.264.1887

to disclose information and to receive information related to mental health treatment information and records obtained in the course of psychotherapy treatment of Patient, including, but not limited to, provider's diagnosis of Patient, to and from:

_____

_____

_____

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at 301 E. Bethany Home Rd, suite C-296, Phoenix AZ 85012 to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

_____

The specific uses and limitations of the types of medical information to be discussed are as follows (*be as specific as you would like*):

_____

_____

Such disclosure shall be limited to the following specific types of information:

_____

Provider shall not condition treatment upon Patient signing this authorization and Patient has the right to refuse to sign this form.

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Patient understands that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA privacy rule, although applicable Arizona law may protect such information.

This authorization shall remain valid until: _____

Patient's signature: _____ Date: _____