David Leicken, MD
Board Certified Psychiatrist

8124 E Cactus Road, Suite 410
Scottsdale, Arizona 85260
602-910-4050

IronwoodBehavioralHealth.com

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I, (name of or parent/guardian if a minor) ______________________________, hereby authorize Dr. David Leicken to obtain information from and release information to:

____

____

____

____

Patient Name: ____ **Date of Birth:** _____________________

Reason for release:

☐ My request ☐ Coordination of Care ☐ Transfer of Care

☐ Other____

Portion of record to be released:

☐ All ☐ Diagnostic Evaluation ☐ Verbal Contact ☐ Diagnostic Test Reports

☐ Summary of Contact with Client ☐ Other (specify) ____

I understand why this information is needed and I am satisfied that it will be held confidential. Photocopies of this form will be considered as valid as the original. This authorization will remain in effect until revoked by me in writing or upon termination of care with Dr. Leicken.

Signed____Date_________________________

Witness____Date_________________________