Dr. Marlo Archer
1237 W. Auburn Dr.
Tempe, AZ 85283
480-705-5007
drmarlo.com

Authorization to Release Confidential Information

Client Name _____

Date of Birth _____

Patient ID _____

I hereby authorize Marlo J. Archer, Ph.D.; dba Down to Earth Enterprises; to:

☐ Release Information to and Receive Information From:

_____
(Person and/or Organization)

_____ _____ _____
(Address) (Phone) (Fax)

☐ Information may be transferred in written or verbal form or electronically.

☐ The specific information to be disclosed may include Mental Health Records, Medical History, Presence in Treatment, Attendance at Sessions, Treatment Goals, Progress in Treatment, and Treatment Termination.

☐ This information is to be used for the purpose of Coordination and Planning of Care.

☐ I understand that my records are protected under the Federal and/or State Confidentiality regulations and cannot be disclosed without my written consent except as otherwise provide for in these regulations. I also understand that I may revoke this consent at any time, in writing, except to the extent that action has already been taken in reliance on it, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim, and that in any event, this consent shall expire 90 days after the termination of treatment.

☐ I understand that information regarding my behavioral health treatment is protected by federal law under the Drug Abuse Prevention, Treatment and Rehabilitations Act and the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and their implementing regulations. See generally 42 C.F.R. Part 2; 45 C.F.R. Parts 160.164. I understand that my health information specified above will be disclosed pursuant to this authorization, that the recipient of the information may redisclose the information and it may no longer be protected by federal law under HIPAA. Federal law governing confidentiality of alcohol and drug abuse patient information noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in an alcohol or other drug program from redisclosure.

☐ I understand that my psychologist generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

Client Print	_____	Sign	_____	Date	_____
Guardian Print	_____	Sign	_____	Date	_____
Witness	_____	Sign	_____	Date	_____