Serenity Therapeutics LLC
753 North Main St, Suite B5, Cottonwood AZ 86326
928-899-0723 info@SerenityTherapeuticsLLC.com

RECORDS REQUEST

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient: _____Date of Birth: _____

Address:_____

Phone:_____ Email: _____

I hereby consent and authorize the release of the following information:

____ Assessment results ____ Report of findings

____ Diagnostic information ____ Summary of clinical sessions

____ Any and all information necessary to assist with treatment planning and care

Information to be released BY:

Serenity Therapeutics, LLC. 753 North Main St Suite B5, Cottonwood, AZ 86326 **928-899-0723**

Information to be released TO:

_____

Entity

_____

Address City State Zip

_____

Phone Fax

I understand that I may revoke this authorization in writing. I understand that once the health care information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I hereby release Serenity Therapeutics, LLC. and/or staff sending and/or communicating the records and results from any liability associated with the release of information. I understand this release will expire twelve (12) months from date of signature unless specified here _____.

_____

Patient Signature Date

_____

Signature of Parent of Legal Guardian (Minor) Date