Nathan H. Azrin, Ph. D. • Victoria Besalel Azrin, Ph. D.
A & B Psychology Clinic
5151 Bayview Drive
Fort Lauderdale, FL 33308
Voice: (954) 491-6984 • Fax (954) 491-7068

Patient Name: _____ Date of Birth: _____

Social Sec. #_____ Date(s) of requested records: _____

I hereby authorize the above providers to obtain and release the protected information specified below.
Please list any restrictions on this release of information_____

Name_____ Phone_____ Fax_____
Address_____
City State Zip

Name_____ Phone_____ Fax_____
Address_____
City State Zip

Name_____ Phone_____ Fax_____
Address_____
City State Zip

Name_____ Phone_____ Fax_____
Address_____
City State Zip

Name_____ Phone_____ Fax_____
Address_____
City State Zip

Records to be Obtained: Please send copies of all EEG, MRI, CT, History and Physical, and the doctors last progress notes.
Release: This form when completed and signed by you, authorizes me to release, as well as obtain, protected information from your clinical record to and from the person(s) you designate. I hereby authorize Dr. Nathan H. Azrin and Dr. Victoria A. Besalel and/or his or her administrative and clinical staff to release any and all contents of my chart (including at least billing information, psychotherapy/progress notes, test results/data, reports, visit information, prescriptions, medical information, documents provided by patient, insurance/third party forms/reports, records received by others). This information should only be released to and/or obtained from the above individuals.
I am requesting my psychologist, psychiatrist, or social worker release this information to aid in treatment and/or assessment and/or provide information about me to others. This authorization shall remain in effect indefinitely. However, you have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
I understand that my psychologist, psychiatrist, or social worker generally may not condition psychological services upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.
I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
I hereby release the above treatment/assessment providers and their respective medical staff and office from any and all liability and claims arising out of or relating to the disclosure and/or release of confidential and/or privileged information.
Informed Consent: I agree to participate in evaluation/treatment, and the purpose has been explained to me and/or my guardian/representative.

_____ _____ _____
Name of patient and/or responsible party Signature of patient or responsible party Date

_____
If signed by patient's representative, a description of representative's authority to act for the patient is provided above.

***** Please fax records to Fax# (954) 491-7068 OR call Voice # (954) 491-6984**