

KEVIN LEEHEY, M.D.

Child, Adolescent, and Adult Psychiatry, ABPN Board Certified
1980 E. Ft. Lowell Rd., Suite 150 Tucson, Arizona 85719
Phone: 520-296-4280 Fax: 520-296-3835

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____

Address: _____

Phone/Fax/Email: _____

The above person, doctor, therapist, clinician, provider or agency and Dr. Leehey are authorized to communicate by phone, electronically, in person, or through records in order to assist them in providing treatment for me or my child.

The patient:

Patient Name: _____

Patient Date of Birth: _____

Information authorized to be disclosed and/or purpose:

I understand that my records are protected under Federal, HIPAA, state, and other confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by HIPAA. I certify that this request has been made freely, voluntarily without coercion and the information given is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time by written notice. By releasing information requested Dr. Leehey is hereby released from all liability that may arise.

Date: _____

Signed _____
(patient)

Signed _____
(parent or guardian)

Witness _____

AUTHORIZATION MUST BE SIGNED BY THE PATIENT, OR BY THE PARENT OR GUARDIAN IN THE CASE OF A MINOR.