REQUEST/CONSENT TO RELEASE RECORDS & INFORMATION

I, _____(print full name)**, born on_____,**
SSN_____, Phone _____,

hereby authorize:
Iluminar, PLLC
10752 N 89th Place Ste 209
Scottsdale, AZ 85260
Tel 480.338.8070
Fax 480.314.5133

To disclose to:
Person or Facility _____
Address _____
_____
Tel _____ Fax _____

For the purpose of:

- ☐ Medical Treatment
- ☐ Plan/Intervention Coordination of Treatment - Referral Source
- ☐ Referral of Patient for Further Treatment
- ☐ Coordination of Treatment - Psychiatrist/Therapist
- ☐ Other _____

Approximate dates of treatment: _____

Information to be released via:

- ☐ Fax
- ☐ Photocopy/Mail
- ☐ Telephone

****PLEASE allow at least 5 business days for your records****
****Processing fee varies from $25-$50 depending on file size****

I understand the purpose of this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implication of their release. This request is entirely voluntary on my part. I am aware that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____ _____ _____
Print Patient or Parent/Guardian Name | Patient or Parent/Guardian Signature | Date

I witnessed that the aforementioned person understood the nature of this request/authorization and freely gave his or her consent.

_____
Print Witness Name | Witness Signature | Date

NOTICE: All information contained herein is strictly CONFIDENTIAL and protected from disclosure. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance of the contents of these documents is strictly prohibited.