Premier Health and Wellness, LLC
4835 E. Cactus Rd. Suite 333
Scottsdale, AZ 85254
(P) 602-795-9980 (F) 602-795-9984

Verbal & Writing Disclosure Authorization

Patient's Name: _____DOB: _____

I do hereby request and authorize Premier Health and Wellness, LLC to be able to contact the following people or organizations for the purpose of "Facilitation of Treatment."

( ) Sonia Godbole, M.D. ( ) Supriya Nair, D.O. ( ) Shaili Patel, M.D. ( ) Alpa Sanghvi, M.D.

Names and relationships of who may be contacted are:

_____ _____
Name/Relationship Phone

_____ _____
Name/Relationship Phone

NAME OF YOUR PRIMARY CARE DOCTOR: _____MAY WE CONTACT? _____

PHONE NUMBER: _____WHEN WERE YOU LAST SEEN? _____

I GIVE MY **CONSENT** FOR MY PHYSICIAN TO RELEASE MY RECORD TO MY PRIMARY CARE DOCTOR SO THAT THEY CAN DISCUSS MY TREATMENT: SIGNED_____DATE_____

I understand that the verbal and written exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. This consent will remain in effect for 12 months from the date of signatures below.

The information disclosed to the authorization parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date