

Behavioral Consultation Services of Northern Arizona (BCSNA)
906 W. University Avenue
Suite 120
Flagstaff, AZ 86001
(928) 556-9935

(Client Name)

(Date of Birth)

AUTHORIZATION FOR THE EXCHANGE OF MEDICAL RECORD INFORMATION

I hereby give permission to _____ to exchange
(Name of person/facility)
medical, social, and psychological information of _____ with
(Patient Name)
Behavioral Consultation Services of Northern Arizona (BCSNA). Please send to the attention
of _____.
(Andrew W. Gardner, Ph.D.)

Restrictions: _____
_____.

This authorizes the exchange of patient information between the BCSNA and the aforementioned provider. The form has been fully explained to me and I certify that I understand its contents.

Signature of person authorized to consent for patient: _____

Relationship to patient: _____

Date: _____

Address: _____

City: _____ State: _____ ZIP: _____

Name of authorized person, facility, or physician: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone Number: _____

Witness Signature: _____

THIS CONSENT EXPIRES ONE YEAR FROM: _____

(Today's Date)