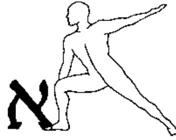
THE *ALEPH* CENTER, P.L.L.C.



6408 East Tanque Verde Road
Tucson, AZ 85715-3809
PHONE: (520) 885-5558 FAX: (520) 885-5559

Welcome, please complete as much of this form as you can. The answers you provide will help us to plan your care. You will only have to fill this form out one time. If you would like a copy let us know and we will be happy to provide one. We will be happy to assist you as needed, Thank you.

Today's date	Patient's name:	Name you prefer to be called:
Date of birth:	Age:	
Emergency contact:	Relationship:	Best contact number:
Primary care physician:	Outpatient psychiatric provider:	Other providers involved in your care:
Reason for today's visit?		
Do you and your family understand your medications and current treatment?	☐ clearly	☐ need more information
What pharmacy do you use? (name and phone number)		

Allergies
(medication/food, indicate reaction)

Medications

Please list ALL medications you take, Include Aspirin, Water Pills, Vitamins, Herbal Supplements, Laxatives, Heart Medicine, Birth Control Pills, ETC.

name of medication	dose(s)	how often

Past medications

Please check any of the medications below that you have taken in the past that you can remember.

Antidepressants

☐ Prozac/fluoxetine	☐ Paxil/paroxetine
☐ Effexor/venlafaxine &/or Pristiq/desvenlafaxine	☐ Celexa/citalopram &/or Lexapro/escitalopram
☐ Cymbalta/duloxetine	☐ Zoloft/sertraline
☐ Luvox/fluvoxamine	☐ Fetzima/milnacipran
☐ Wellbutrin/bupropion	☐ Remeron/mirtazapine
☐ Serzone/nefazodone	☐ Trintellix/vortioxetine
☐ Viibryd/vilazodone	☐ Ketamine/esketamine

Tricyclic Antidepressants (TCA's)

☐ Anafranil/Clomipramine	☐ Pamelor/Nortiptyline
☐ Elavil/Amitriptyline	☐ Norpramin/Desipramine
☐ Tofranil/Imipramine	☐ Sinequan/Doxepin
☐ Vivactil/Protriptyline	☐ Ludiomil/Maprotiline

MAOI's

☐ Parnate/Tranylcypromine	☐ Nardil/Phenelzine
☐ Marplan/isocarboxazid	☐ Eldepryl/Selegeline
☐ Emsam Patch/selegiline	

Alternative/Agents

☐ St. John's Wort	☐ SAM-e
☐ Omega 3 Fatty Acid	☐ Valerian
☐ Kava Kava	☐ Gingko
☐ Gingseng	

Non-Medications Treatment

☐ Transcranial Magnetic Stimulation(rTMS)	☐ Vagal Nerve Stimulation (VNS)
☐ ECT	

Antipsychotics

☐ Risperdal/Risperidone	☐ Zyprexa/Olanzapine
☐ Seroquel/Quetiapine	☐ Clozaril/Clozapine
☐ Geodon/Ziprasidone	☐ Abilify/Aripipazole
☐ Invega/paliperidone	☐ Fanapt/iloperidone
☐ Latuda/lurasidone	☐ Saphris/asenapine
☐ Vraylar/cariprazine	☐ Rexulti/brexpiprazole
☐ Haldol/Haloperidol	☐ Thorazine
☐ Loxitane/Loxapine	☐ OTHER(S):

Drug & Alcohol

☐ Naltrexone	☐ Campral/acamprosate
☐ Antabuse/disulfuram	☐ Buprenorphine

Medications for Dementia

☐ Tacrine	☐ Aricept/donepezil
☐ Exelon/rivastigmine	☐ Razadyne/galantamine
☐ Namenda/memantine	

Sleep Aids

☐ Desyrel/Trazodone	☐ Benadryl/Diphenhydramine
☐ L-TRP/Tryptophan	☐ Ambien
☐ Sonata	☐ Chloral Hydrate
☐ Lunesta	☐ Rozerem
☐ Melatonin	☐ Belsomra

Treatment for ADHD

☐ Ritalin/Concerta	☐ Dexedrine
☐ Adderall	☐ Strattera

Mood Stabilizers/Anticonvulsants

☐ Lithium	☐ Tegretol/Carbamazepine
☐ Trileptal/oxcarbazapine	☐ Depakote/Valproate
☐ Lamictal/Lamotrigine	☐ Gabitril/Tiagabine
☐ Topamax/Topiramate	

Medications for Sleep Disorders

☐ Provigil/Nuvigil (modafinil/armodafinil)	☐ Xyrem/Sodium Oxybate

Anti Anxiety Agents

☐ Xanax/Alprazolam	☐ Ativan/Lorazepam
☐ Klonopin/Clonazepam	☐ Serax/Oxazepam
☐ Tranxene/Clorazepate	☐ Librium/Chlordiazepoxide
☐ Valium/Diazepam	☐ Prosom/Estazolam
☐ Dalmane/Flurazepam	☐ Restril/Temazepam
☐ Buspar/buspirone	☐ Vistaril/Hydroxyzine
☐ Medical MJ,THC,CBD	☐ Neurontin/Gabapentin

Psychiatric History

Have you ever participated in individual or group therapy and/or seen a psychiatrist? ☐ Yes ☐ No

Have you ever been treated for any of the following? ☐ yes ☐ no (If Yes, Check all that apply)

☐ depression ☐ anxiety/panic ☐ adjustment problem(s) ☐ eating disorder ☐ chemical dependency ☐ other

If you answered "Yes" to either of the above questions please give the date(s) and indicate treatment effectiveness:

Medical History

Please check all that apply

Cardiovascular	Current	Past	Never	Endocrine/Other	Current	Past	Never	Gastrointestinal	Current	Past	Never
High Blood Pressure				Diabetes Type 1				Nausea and Vomiting			
Heart Attack				Diabetes Type 2				Heartburn/indigestion			
Chest Pain/Angina				Thyroid Disease				Ulcers			
Pacemaker				Adrenal disease				Loss of Appetite			
Internal Defibrillator				Immune disorder				Colostomy			
Irregular Heart Rhythm/Murmur				Blood Disorders-Bleeding				Diarrhea			
Swelling of Ankles				Anemia				Constipation			
Cardiac Catherization/Angioplasty				Cancer				Change in Stool			
Circulation Problems				**HEENT**				Liver Disease			
Congestive Heart Failure				Hearing loss				Hiatal Hernia			
Genitourinary				Glaucoma				Hepatitis			
Difficult or painful urination				Cataracts				**Musculoskeletal**			
Kidney stones				Hay Fever/ Allergies				Rashes/Bruises/Sores			
Frequent urination				Vision Loss				Arthritis			
Prostate Problems				Nosebleeds				Limited Mobility			
Kidney Disease				**Respiratory**				Have you fallen recently			
Urinary Infections				Shortness of Breath				**Prosthesis/Assistive**			
Venereal disease				Chronic Cough							
Last menstrual period				Cold/Sore Throat				Valves			
				Asthma/ Bronchitis				Joints			
Pregnant				Oxygen at home				Eyes			
Neurological				Tuberculosis				Hearing Aids			
Headaches				Phlegm				Dentures/Teeth			
Seizures				Chronic Lung Disease				Contact lens			
Faintness/dizziness				Sinus infection				Glasses			
Weakness/Tingling Numbness											
Stroke											

To your knowledge, was your mother's pregnancy with you normal? ☐ yes ☐ no If no please explain:

Childhood: Major Illnesses/Injuries/handicaps/surgeries:

Pain History

Do you have Pain? ☐ yes ☐ no ☐ new ☐ chronic

How do you manage your pain at home? ☐ well ☐ marginally ☐ not at all

Continuum of Care

Do you live alone? ☐ yes ☐ no Are others dependent on you for their care? ☐ yes ☐ no

Do you live in a nursing home, adult care home, or use home health services? ☐ yes ☐ no

Facility Name: ______________________________ Facility phone: ________________

Do you have assistance available for your daily care?(example meals, bathing, transportation) ☐ yes ☐ no

Do you feel safe at home? ☐ yes ☐ no

Psychosocial History

Do you have an advance directive/living will? ☐ yes ☐ no Where is it located?

Do you have a durable power of attorney? ☐ yes ☐ no

If you have either please bring a copy with you next time.

Are you an organ donor? ☐ yes ☐ no

Are there any situations that are causing you stress? ☐ yes ☐ no

Explain: ____

Past Surgical History (indicate date if known)

☐ Adenoidectomy	☐ C-Section	☐ Tonsillectomy
☐ Appendectomy	☐ Heart Valve	☐ Tubal Ligation
☐ Bowel/Stomach Resection	☐ Hernia	☐ Prostate Surgery/Resection
☐ Cardiac Stents	☐ Hysterectomy	☐ Bladder Surgery
☐ Cataracts	☐ LASIK	☐ Spinal Surgery
☐ Colonoscopy	☐ Pacemaker	☐ Bariatric Surgery
☐ Coronary Bypass	☐ Thyroidectomy	☐ Orthopedic/Joints
☐ Other		

Social/Dietary Habits

How many meals do you eat a day?	When is your largest meal?
Do you eat a special diet (specify)	
How much coffee/tea /caffeine do you drink each day?	How much alcohol do you drink?
Any change in appetite? ☐ Yes ☐ No	Have you ever smoked? ☐ Yes ☐ No
How much do you smoke?	How long have you smoked?
Smoking start date:	Smoking stop date:
Usual Weight:	Current Weight:

Family Medical & Psychiatric History

Is there any family history of emotional problems? ☐ no ☐ yes (please explain)

Is there any family history of any mental health diagnosis? ☐ yes ☐ no

Has anyone in your family completed a suicide? ☐ yes ☐ no

Has anyone in your family been institutionalized? ☐ yes ☐ no

Has anyone in your family has problems with substance abuse? ☐ yes ☐ no

Social History

Family of Origin

As a child who did you live with? ☐natural, ☐ adoptive, ☐step-parents, ☐grandparents, ☐ in a foster home?
List all that apply and explain:

How many brothers and sisters did you have? Number of brothers Number of sisters
Which child were you?

Brothers/Sisters

name	alive/deceased	amount of contact

Mother: age: age at death: year of death:

Cause of death:

Quality of relationship (past or present:):

Father: age: age at death: year of death:

Quality of relationship (past or present):

Parent's relationship:

Marital/Relationship History

Sexual Orientation: ☐ bisexual ☐ gay/lesbian ☐ heterosexual ☐ other

Gender Identity: ☐ male ☐ female ☐ transgender ☐ other

☐single ☐married ☐widowed ☐divorced ☐other

Number of Marriages:

	age	length	termination	children	spouse's name
1st marriage					
2nd marriage					
3rd marriage					
4th marriage					

Describe the relationship of current and/or past marriages:

Children

Name	Age	Alive/deceased	Amount of contact	Quality of relationship past/present

miscarriages, abortions, stillbirths:

Environment

Do you live in a ☐house ☐apartment ☐ nursing home ☐ other

Do you : ☐rent ☐own ☐live with relatives

Who are the members of your household?

Financial summary: (Include resources, stability of resources and ability to live on current income)

Vocational/Avocational History

Education: grade completed: Trade school/college attended:

Current employment status: ☐ employed full time ☐ employed part time ☐ simi retired date:
☐ retired date: ☐ disabled date:

Are you satisfied with your current employment status?

Work history:

Hobbies and Interests (past and present):

Military History ☐ Not Applicable

Branch of service: rank: date: from To

assignments:

Wounded in action?

Type of discharge:

Peer Relationships/Social Life

Describe peer relationships:

Has anyone important to you died or moved away recently? ☐ Yes ☐ No

Who?

Describe your social life, past and present:

Club and/or organization affiliation, past and present

Cultural Influences/Spiritual History

Are there any particular cultural influences you feel need to be taken into consideration while you are in treatment?

Religious affiliations:

Present/past participation in church:

Drug and Alcohol History

Have you ever used Illegal drugs? ☐ yes ☐ no (If yes, check all that apply)

☐ marijuana ☐ LSD ☐ mushrooms ☐ peyote ☐ other hallucinogens ☐ cocaine ☐ speed ☐ huffing gas
☐ Paint
☐ stimulants (meth, cocaine) ☐ opiates (heroin, RX) ☐ I.V. drugs ☐ other drugs
Explain:

Have you ever sought treatment for drug abuse? ☐ Yes ☐ No

Has or anyone in your family attended/ing any other support groups? ☐ Yes ☐ No

If yes, Specify who and what group:

Are you concerned about drinking/drug abuse? ☐ Yes ☐ No If yes, why?

What changes about your personality when you drink or use?

When did you first become concerned and why?

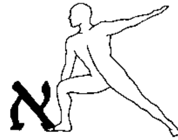
Patient/Family Signature

Date Time

THANK YOU FOR CHOOSING US TO HELP YOU.

THE *ALEPH* CENTER, P.L.L.C.

THE *ALEPH* CENTER, P.L.L.C.



6408 East Tanque Verde Road
TUCSON, AZ 85715-3809
PHONE: (520) 885-5558   FAX: (520) 885-5559

GENERAL INFORMATION – THE *ALEPH* CENTER, P.L.L.C. is a private organization specializing in the comprehensive care of people with psychiatric disorders including but not limited to geriatrics, anxiety disorders, mood disorders and substance abuse disorders. We keep open communication with your primary care provider and other specialists (unless you direct us otherwise) to provider full service mental health care.

OFFICES – The office is open Monday through Friday 8:00am to 5:00pm. We see patients by appointment only, but may see patients by prior arrangement outside the above hours. However, we are sometimes out of the office seeing hospital and nursing home patients and may not be available all of the above times.

EMERGENCY NUMBER – Our administrative assistants are in the office Monday through Friday 9:00am to 4:30pm to make appointments and take messages. We will return messages before 6:00pm if left prior to 4:30pm. For emergencies, call 911 or go to the nearest emergency room. You may have us paged when prompted. We may take up to 30 minutes to respond.

APPOINTMENTS/CANCELLATIONS/NO SHOWS – We require you to notify the office of a cancellation no later than the business day (24 hours) prior to your appointment. Failing to do so results in you having to pay a **$50.00** late charge if you are seeing a therapist or **$100.00** late charge if you are seeing a physician (Insurance does NOT pay for this). Our office provides a courtesy confirmation call the day before your appointment. **Not receiving a call will NOT excuse a missed appointment**.

Please Initial: ___________________________

PAYMENT IS EXPECTED AT TIME OF VISIT

PAYMENT – Co-Payment is expected at the time of service. We accept most major medical insurers; cash, checks, Visa or Mastercard, and we will bill your insurance carrier for you. However, if payment is not received within 60 days, it becomes your full responsibility.

BALANCES – In excess of 30 days are subject to a monthly service charge of one and one half percent or $5.00, whichever is greater, on the entire balance.

CHARGES

Provider	*Billing Code	Fees
Doctor/NP	90791-90792	$300.00
	90833	$190.00
	90836	$200.00
	90870	$300.00
	99245	$300.00
Therapist/LCSW	90791	$250.00
	90834	$140.00
Court Paperwork/ I and E Exams		$450.00, plus $300 per additional hour.

*** Billing codes are subject to change.**

Please Initial: ___________________________

PATIENT OR RESPONSIBLE PARTY AGREEMENT: I / We have read and do understand the General Information form. I / We agree to the provisions stated herein. I / We consent to the release of appropriate treatment and legal information to the primary care physician, referring doctor or other professional, and the insurance company or any other third party paying for fees. I / We authorize payment of medical benefits directly to THE *ALEPH* CENTER, P.L.L.C.

The provider has reviewed the General Information form with me.

____

Date Signature of Patient or Responsible Party

____

Printed name

Patient Registration Information

PLEASE COMPLETE AS MUCH INFORMATION AS POSSIBLE

Patient Name:	Home Phone: ( )		Date of Birth / /	Age:
Address:	Gender (birth/biological): Male Female Other		Social Security Number:	
City:	State:	Zip Code:	Marital Status: Single / Married / Widowed Divorced / Remarried / Co-habitating	
Employer:	Occupation:		Work Phone :	
Race:	Religion:		Primary Care Provider:	

RESPONSIBLE PARTY / PRIMARY CARD HOLDER

Name:	Date of Birth: / /	Social Security No:	Relationship:	Home Phone: ( )
Address:	City:		State:	Zip Code:
Employer:	Occupation:	Work Phone: ( )		

NOTIFY IN CASE OF EMERGENCY

Name:	Relation:	Home Phone:	Work Phone:
Address:	City:	State:	Zip:

REFERRED BY

Provider:	Family Member: Father / Mother / Brother / Sister Daughter / Son	Other: Father-In-Law / Mother-In-Law / Brother-In-Law Sister-In-Law / Daughter-In-Law / Son-In-Law Niece / Nephew / Cousin / Friend

INSURANCE INFORMATION

Primary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:
Secondary Behavioral Health Insurance Carrier:	Carrier's Phone Number:	Identification No:

Our office provides the service of a courtesy reminder call the day before your appointment. To protect your privacy, please indicate how you would prefer this to be done (please check any of the following):

- ❑ Leave a message at your home phone number.
- ❑ Call you at your work / alternate phone number:_________________________________
- ❑ You prefer that staff does not confirm your appointment.

Our office requires that you notify us of a cancellation no later than the business day (before 12:00pm) prior to your scheduled appointment. Failing to do so results in you having to pay a $50.00 late charge if you are seeing a therapist or a $100.00 late charge if you are seeing a physician (Insurance does NOT pay for this). Not receiving a call will NOT excuse a missed appointment.

PLEASE READ AND SIGN:

I authorize the release of any of my medical, psychiatric, or other information necessary to process any claim and provide information to another health care provider when necessary to coordinate treatment. I also authorize payment of medical benefit to the physician or supplier for services rendered. I fully understand that if my insurance denies payment for any service defined as a non-covered service, I will be responsible for any amount due.

SIGNED:____ DATE:_______/_______/________

The Aleph Center, P.L.L.C.

6408 E. Tanque Verde Rd.
Tucson, AZ 85715-3809
(520) 885-5558 fax (520) 885-5559

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights and notices regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment,

payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to The Aleph Center.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to The Aleph Center. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Dr. Kevin Goeta-Kreisler, Medical Director. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

8. An appointment gives us implicit consent to view your medication history that is provided by your Pharmacy Benefit Manager (PBM), the State of Arizona Prescription Monitoring Program and your pharmacy to help in providing your care.

If you have any questions regarding this notice or our health information privacy policies, please contact any of our office staff.

I hereby acknowledge that I have been presented with a copy of The Aleph Center, PLLC's Notice of Privacy Practices.

Signature ____

Date ____

Print Name of Patient ____

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❍	❍
...you were so irritable that you shouted at people or started fights or arguments?	❍	❍
...you felt much more self-confident than usual?	❍	❍
...you got much less sleep than usual and found you didn't really miss it?	❍	❍
...you were much more talkative or spoke much faster than usual?	❍	❍
...thoughts raced through your head or you couldn't slow your mind down?	❍	❍
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❍	❍
...you had much more energy than usual?	❍	❍
...you were much more active or did many more things than usual?	❍	❍
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❍	❍
...you were much more interested in sex than usual?	❍	❍
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❍	❍
...spending money got you or your family into trouble?	❍	❍
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❍	❍

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	❍	❍
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	❍	❍

© 2000 by The University of Texas Medical Branch. Reprinted with permission. This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

PHQ-9 & GAD-7

	Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or over eating	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

PHQ9 – Total Score

	Over the last 2 weeks, on how many days have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

GAD7 – Total Score

mentUcate 2014

Release of Information

The Aleph Center, P.L.L.C.
6408 E. Tanque Verde Rd.
Tucson, Az. 85715
(520)885-5558 Fax (520)885-5559

Printed Name: ______________________________ Date of Birth: ______________

Street Address: ____

City, State, Zip Code: ____________________ Telephone: ____________________

1. **Information to be disclosed-Covering the Periods of Health Care**: (There may be a fee for copying these records).
   From (date) ____________________ To (date) ____________________
   - ❑ Complete Health Record(s)
   - ❑ Progress Notes
   - ❑ History and Physical Examination
   - ❑ Laboratory Tests
   - ❑ Consultation Reports
   - ❑ X- Ray Films
   - ❑ Reports only
   - ❑ Photographs, videotapes, digital/other images
   - ❑ Verbal Communication Only **(DO NOT SEND RECORDS)**
   - ❑ Other (Please specify) ______________________________

Please Mail If Over 20 Pages!!!

2. **Purpose of Request:**
   - ❑ Treatment/Consultation
   - ❑ Insurance Copy
   - ❑ Attorney
   - ❑ Personal Copy
   - ❑ Verbal Communication Only **(DO NOT SEND RECORDS)**
   - ❑ Other (Please specify) ______________________________

Person Authorized to Disclose Information:

____

____

Person Authorized to Receive Information

____

____

4. **Drug and/or Alcohol Abuse, Communicable Disease, Psychiatric, and or HIV/AIDS/Genetic Testing Records Release:**
I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Diseases, Psychiatric, and/or Genetics Testing may be released. ______Yes (initials) ______No (initials)

I agree that any medical or billing record containing information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment may be released. _______Yes (initials) ______No (initials)

5. **Time Limit & Right to Revoke Authorization:**
   I understand that I can revoke this authorization at any time by submitting a written notice to the Custodian of Records at the location where records are located; however, I understand that if I do not act quickly to revoke this authorization, my records may have already been released.
   Unless revoked, this authorization will be valid until the information is released.

6. **Re-disclosure:**
   I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The Aleph Center, its employees, officers and physicians are hereby released from any legal responsibility for disclosure of the above information.

7. **Signature of Patient or Personal Representative Who May Request Disclosure:**

   Signature ______________________________ Date: ______________

   Print ______________________________ Authority to sign if not patient ______________

8. Witnessed by: ______________________________