

Release of Information

from Integrated Health and Behavior, PLLC

Patient's Name: _____ Date of Birth: _____
Phone Number(s): _____ Previous Name: _____

I request and authorize the release of my healthcare information:

To:

Provider Name: _____
Address: _____
Phone Number(s): _____
Fax Number: _____

From:

Integrated Health and Behavior, PLLC
2310 N Molter Rd, Ste 105, Liberty Lake, WA 99019
Phone: 509-891-7867 Fax: 509-922-0984

Information to be released:

Information relating to the following treatment, condition, or dates: _____

All healthcare information

Restrictions: _____

This consent includes authorization to release alcohol, drug abuse, health, and mental health records obtained, in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to the extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for one year or until it is revoked in writing by me. I understand that I am not required to sign this consent in order to receive treatment f.

Patient Signature: _____ Date Signed: _____
Signature of Parent or Guardian: _____ Date Signed: _____

THIS AUTHORIZATION IS VALID FOR 1 YEAR AFTER SIGNING