Integrated Health and Behavior, PLLC

Consent for Release of Confidential Mental Health, Substance Abuse, and/or Health Records
To Family Members

AUTHORIZATION FOR: Integrated Health and Behavior Staff

TO RELEASE CONFIDENTIAL INFORMATION:
☐ **Verbally only** ☐ **Both verbally and written**

I, ______________________________, request and authorize the release of my healthcare information to:
(print name)

Persons to whom information may be disclosed (please print names):

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Information to be released:
☐ **All healthcare information, or:**
☐ Appointment times and information
☐ Information relating to the following treatment, condition, or dates: ______________________
☐ Recent chart note(s)
☐ Treatment plan
☐ Assessment
☐ Lab records
☐ Medications
☐ Psychological/drug testing

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. I understand that I am not required to sign this consent in order to receive treatment.

Patient Signature: ____ Date Signed:______________

Signature of Parent or Guardian:_________________________________ Date Signed:_______________

THIS AUTHORIZATION IS VALID UNTIL REVOKED