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
18211 E Appleway Ave, Spokane Valley, WA 99016
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