CENTER FOR INTEGRATED
BEHAVIORAL HEALTH

AUTHORIZATION TO **RECEIVE** AND **RELEASE** INFORMATION

I, ____________________________, authorize _____________________ at Center for Integrated Behavioral Health to discuss my child's information and treatment (includes any pertinent psychological and medical background information and current issues) with the following parties:

1. Name: ________________________________Affiliation: ____________________________

Address: ____

Phone Number: ____

2. Name: ________________________________Affiliation: _____________________________

Address: ____

Phone Number: ____

I understand this authorization will expire 6 months after termination of treatment or at any time prior upon written request.

I hereby consent that this communication can take place through:

____ *telephone* _______ *fax* ______ *email* ______ *mail*

I understand that email is not a confidential method of communication and that there is a risk that email communications may be intercepted by a 3rd party or may be transmitted to unintended parties. I am aware that the staff at Center for Integrated Behavioral Health will take all necessary measures to avoid using identifying information in email communications.

Date: ____________________

Name of Authorized Patient Representative (Print): ____________________________________

Signature of Authorized Patient Representative: ____

Authorized Representative's Relation to Patient: _______________________________________

Clinician Signature: ____

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