CENTER FOR INTEGRATED
BEHAVIORAL HEALTH

AUTHORIZATION TO RECEIVE AND RELEASE CONFIDENTIAL INFORMATION

I, _____ authorize _____at
(Clinician's name)
Center for Integrated Behavioral Health to release and receive confidential information (includes any pertinent psychological, medical and Educational information) 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 completion of the evaluation, 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.

Date_____

Name of Patient: _____

Signature of Patient: _____

Clinician Signature: _____

CENTER FOR INTEGRATED BEHAVIORAL HEALTH, LLC
One Bethlehem Plaza, Suite 810, 1 West Broad Street, Bethlehem, PA 18018
Phone: 610-865-4300 Fax: 610-865-4399
www.centerforibh.com