INTEGRATED BEHAVIORAL CARE, P.A.

35 BEECHWOOD ROAD, SUITE 3A/B, SUMMIT, NJ 07901
PHONE: 908-598-2400 FAX: 908-598- 2408 WEBSITE: WWW.INTEGRATEDBEHAVIORALCARE.COM

CONSENT TO RELEASE INFORMATION

PATIENT NAME: _____ DOB: _____/_____/_____

PARENT/GUARDIAN: _____
(if patient under 18)

I hereby authorize: _____
Treating Provider / INTEGRATED BEHAVIORAL CARE, P.A.

☐ **release records to** ☐ **obtain records from**

the following individual / agency listed below regarding the above named patient for the purpose of coordinating care between provider(s):

Individual / Agency: _____

Address: _____

_____

_____

Phone Number: _____ Fax Number: _____

Information to be disclosed includes medical/psychiatric/social:

☐ history ☐ diagnosis ☐ treatment ☐ testing ☐ recommendations ☐ written summary

_____

_____

SPECIFIC AUTHORIZATION FOR RELEASE OF OTHER INFORMATION PROTECTED BY STATE OR FEDERAL LAW
I specifically authorize the release of data and information related to:

☐ Substance (drug / alcohol) Abuse ☐ HIV related information

_____ _____
PATIENT SIGNATURE (IF 14 OR OLDER) DATE

_____ _____
PARENT/GUARDIAN SIGNATURE (IF UNDER 18) DATE

This includes authorization for INTEGRATED BEHAVIORAL CARE, P.A. to share information both verbally and in writing. I understand that some or all of the information that may be disclosed under this document may be individually identifiable health information as described above. I understand that my request is wholly voluntary on my part. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations. I hereby release the source of these records from any liability arising from their release and/or receipt. I understand that provision of services is not contingent upon this releasing of records. I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken.

If you sign the authorization below, you are authorizing release of the information described herein.

_____ _____
PATIENT SIGNATURE (IF 14 OR OLDER) DATE

_____ _____
PARENT/GUARDIAN SIGNATURE (IF UNDER 18) DATE

_____ _____
SIGNATURE/TITLE OF STAFF COMPLETING FORM DATE