CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I ________________________________ ___________, hereby request and authorize
(Print name) (D.O.B.)
Integrated Behavioral Services, Inc. to:

Disclose Information To **Obtain Information From** **Verbally speak with**

_______________________________________ ______________________________
PCP Referring Physician and/or Therapist Phone Number

_______________________________________ ______________________________
Street / Mailing Address Suite

_______________________________________ ______________________________
City State Zip Code

Please notate what you wish to have released from the following Information:

Psychiatric Evaluation Psychological Testing Inpatient Hospitalization

Medical History Treatment Compliance Coordination of Care

Other ____

This consent to release the above information will expire one (1) year after the date following my signature below, or sooner by my choice, in which case this will expire on ___________________.
I understand that I may revoke, in writing, my consent at any time except to the extent that action has already been taken.

I also give my permission to release information concerning treatment, diagnosis, or testing of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological. conditions, Acquired Immune Deficiency Syndrome (AIDS), AIDS - related complex (ARC) and/or testing for antibodies to the AIDS virus (HIV).

____ _________________
Patient/ and or Guardian Signature Date

IF YOU DO NOT WISH TO GIVE CONSENT FOR US TO CORRESPOND TO ANYONE PLEASE CHECK BELOW AND SIGN, UNDERSTANDING THAT IF YOU WISH TO REVOKE THIS AT ANY TIME WE NEED WRITTEN CONSENT TO DO SO.

I DO NOT GIVE MY CONSENT TO RELEASE ANY MEDICAL INFORMATION.

____ _________________
Patient/ and or Guardian Signature Date