INTEGRATIVE BEHAVIORAL CARE

ADULT & ADOLESCENT PSYCHIATRIST

PATIENT CONSENT RELEASE CONFIDENTIAL INFORMATION

________________________________(Patient Name) give permission to _________________________ INTEGRATIVE BEHAVIORAL CARE and my Primary Care Physician __________________________________ (Primary Care Physician) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 365 days from the date of signing and I can choose to cancel it at any time

______________________________ Patient/Authorized Representative

______________________________ Date

______________________________ Witness

______________________________ Date

Patient Refusal to Release Confidential Information

_______________________________ (Patient Name) DO NOT give permission to ___________________________ INTEGRATIVE BEHAVIORAL CARE and my Primary Care Physician___________________________ to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

______________________________ Patient/Authorized Representative

______________________________ Date

______________________________ Witness

______________________________ Date

This consent form expires 365 days from the date of signing and I can choose to cancel it at any time.