Consent for Release of Confidential Mental Health/Substance Abuse/Health Records

I _____ _____
name of patient date of birth

Authorize: Integrated Health and Behavior, Ltd. Jeff Wirthlin, M.D.
2310 N Molter, Ste 105
Liberty Lake, WA 99019
(509) 891-7867 phone
(509) 922-0984 FAX

Release to (circle one): Dr. Jeff Wirthlin Self Other: _____

Obtain From:_____
name

_____
address city state zip

_____
phone number fax number

For the Purpose of (circle one): Initial/Continued Care Personal Litigation
Insurance Claim Other:_____

To Be Disclosed Verbally only or both verbally and written

Information to be disclosed (please initial):

___ Entire Record
___ Last Chart Note/Notes
___ Assessment
___ Lab Records
___ All Records From Date Forward:_____
___ Report/Psychiatric Evaluation
___ Psychological/drug Testing
___ Other:_____

RESTRICTIONS:_____

This consent includes authorization to release alcohol, drug abuse, health, and mental health records obtained, in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to the extent the action has already been taken in reliance hereon and if not revoked sooner in writing. **This consent is valid for 90 days unless revoked in writing prior to the 90 days.** I understand that I am not required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study.

Please note when you request records to be released to a third party, that party may NOT be subject to disclosure or privacy regulations.

Patient Signature:_____ Date:_____

Parent or Guardian:_____ Relationship:_____

Witness Signature:_____ Date Sent Out:_____