Consent for Release of Confidential Mental Health/Substance Abuse/Health Records **To Family Members**

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: Dr. Jeff Wirthlin

For the Purpose of: Continued Care

To Be Disclosed (please initial): Verbally only___ Both verbally and written ___

Person(s) to whom information may be disclosed (please write name(s) of individual Dr. Wirthlin may speak with):

_____

_____

Information to be disclosed (please initial):

___ Entire Record
___ Appointment Dates and Times
___ Last Chart Note/Notes
___ Assessment
___ Lab Records
___ Current Medications
___ All Records From Date Forward:_____
___ Treatment Plan
___ 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. The consent is **valid for one year unless revoked sooner in writing by me**. 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:_____