INTEGRATED BEHAVIORAL HEALTH

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Release of Information

Please fill out this form to authorize access to your medical records.
(**Please note:** if you are participating in the Athelas program, you will need to reach out externally to Athelas to obtain your medical records.)

Examples of use for this form is to allow spouses, parents (for those over the age of 18), employers, workers compensation, or other people to access your records. Do not fill out this form if you do not want to grant access to your medical records to anyone. We are not able to share any of your information (appointment details, medical diagnosis, etc..) with another person unless this form is filled out.

**1. I authorize Integrated Behavioral Health to release or obtain my protected health information, described in this form, to/from the following person (s), organization or entity.

**1 (b). Please classify the relationship with the person you are authorizing to access information. Examples include spouse, parent, employer, workers compensation, other medical provider. (optional)

**1(c). Please provide the contact information you have available, including phone, email, and address. (optional)

2. Effective Period This authorization for release of information covers the period of healthcare from: (if you do not respond, then all past, present, and future periods will be covered by this release). (optional)

Offices of:
Andrew Morson MD
Mehdi Qalbani MD
Morgan Feibelman MD
Jill McCall MD
[illegible] MD
Elizabeth Ault MD
Jessica Clark MD
Jennifer Greco MD
Erica Meyers PhD
Karen Pellerin PsyD
Erin Stevens, LPC
Nicole Leon, LPC
Melanie Wilson,LPC
Christa Maureer, LPC
Casey Sommers, LPC

3. Extent of Authorization a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse). (please answer yes or no)

3. Extent of Authorization If you answered no to the above question, please list the exceptions you would like to make to your release of information? Examples include Mental health records, Communicable diseases (including HIV and AIDS), and or Alcohol/drug abuse treatment. (optional)

**4. This authorization shall be in force and effect until the (date or event entered below), at which time this authorization expires. If I do not specify a time, 2 years after signature will be considered the default authorization timeframe.

5.This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by

federal or state law.

_____

Signature Date

☐ I am the parent/guardian of this patient _____

Initial