INTEGRATION MENTAL HEALTH (IMH) RELEASE OF INFORMATION

PATIENT NAME: DOB:

FACILITY TO RECEIVE / RELEASE RECORDS: INTEGRATION MENTAL HEALTH
IMH ADDRESS: 1919 65TH AVE, # 3 GREELEY, CO 80634
P: 970-590-1138 F: 970-356-7437

FACILITY TO RELEASE/ RECEIVE RECORDS: _____

P: F

By placing initial in each applicable space, I, and/ or guardian, authorize disclosure of health information for the purpose of coordination / continuation of care.

_____ Intake/ Initial Assessment

_____ Chart Progress Notes

_____ History & Physical / Medical Evaluation

_____ Hospital Records

_____ Diagnostics / Labs

_____ Discharge Summary

_____ Psychiatric Evaluation and Mental Health Notes

_____ Substance Abuse History / Treatment

_____ Psychological Evaluation(s)

_____ HIV / AIDS Status

Dates of Service: _____

I, the patient/ guardian, understand that records for Behavioral Health treatment / facilities may contain mental health treatment information and or HIV / AIDS test results / treatments. This may include drug / alcohol use information which is protected under Federal Regulations (42 CFR paragraph 2) and cannot be disclosed without my written consent unless otherwise provided for in these regulations. The signature below confirms my consent to disclose the protected information.

Signature: _____ Date: _____

Relation to Patient: Self or Guardian

Printed Name of Guardian: _____ P: _____

Witness: _____ _____(Signature/Printed Name)

Revocation Signature and Date: _____