INDEPENDENT BEHAVIORAL HEALTH GROUP
AUTHORIZATION TO RELEASE HEATHCARE INFORMATION
PHONE: 810-733-5735 FAX: 810-733-5733

Patient's Name: _____ Date of Birth: _____

Other Names Used: _____ SS #: _____

Address: _____ City: _____ Zip: _____

Phone #: _____

I request and authorize:

Independent Behavioral Health Group

- ☐ To ***release*** healthcare information of the patient named above to:
- ☐ To ***obtain*** healthcare information of the patient named above from:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

I also allow Independent Behavioral Health Group to give out medical information regarding my care to the following:

Name: _____ Phone:_____ Relationship:_____
Name :_____ Phone:_____ Relationship: _____
Name: _____ Phone:_____ Relationship: _____
Name: _____ Phone:_____ Relationship: _____

This request and authorizations apply to the following:

- ☐ Healthcare information relating to the following treatment, condition, or dates:
  _____
  _____
- ☐ All Healthcare information
- ☐ Other: _____

- ☐ I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.
- ☐ Limitations: If there is specific information you do not want disclosed please indicate here. If yes please use the space provided below to indicate the information you would like limited:
  _____
  _____

Patient Signature: _____ Date: _____
Printed Name: _____
Witness Signature: _____ Date: _____