Center For Integrated Well-Being, Inc.

AUTHORIZATION FOR RELEASE OF INFORMATION

Primary Care Provider:_____

Clinic Affiliate:_____

Address:_____Phone:_____FAX:_____

Covering the treatment period of:_____ to _____

I hereby give my permission to Staff at the Center for Integrated Well-Being, Inc. to exchange information regarding my case for the purposes of consultation and treatment planning with the above physician and/or clinic.

I understand that my clinical records are protected under State and Federal privacy regulations and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that I may cancel this consent any time prior to the information being exchanged and that in any event, this consent form expires automatically 365 days after signing.

This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form.

Signed: _____ Date:_____

Print Name: _____ Relationship: _____
(Adult for Minor Client) (Self, Parent, Legal Guardian)