Integrated Behavioral Health Solutions, Inc.

RELEASE OF INFORMATION

All information received by Integrated Behavioral Health Solutions will only be used for legitimate purposes, and confidentiality of all client records will be maintained in accordance with all applicable federal and state law.

Child's name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip: _____

The undersigned hereby authorize Integrated Behavioral Health Solutions to send or receive the information listed below to or from the following agencies or entities:

Agency / Entity: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Agency / Entity: _____

Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

TYPE OF INFORMATION Medical ____ Psychiatric ____

Educational ____

Any other information that might be helpful in planning interventions, i.e. _____

The undersigned authorize Integrated Behavioral Health Solutions to release these records only for the following purposes: Verification of Medicaid coverage in order to render services.

_____ _____

(Parent / guardian name) (Date)

_____

(Parent / guardian signature)