IME BEHAVIORAL HEALTH, LLC

RELEASE OF INFORMATION

I hereby authorize IME Behavioral Health, LLC to receive/release information about

CLIENT NAME:____________________________________ DOB:________________

for the purpose of coordinating care/completing medical records requests with:

NAME OF THERAPIST/PSYCHIATRIT/AGENCY/OTHER:_______________________________

Address:____

Phone:_____________________________ Fax:________________________________

The information to be disclosed includes:

_______Evaluations, Reports, Progress Notes

_______Discharge Summary

_______Treatment Plan, Recovery Plans, Aftercare Plans

_______Test Results/School Records

_______Payment/Billing Information

_______Appointment Record

_______Medication Summary

Other:____

This release of information shall remain in effect until:____________________________________

Printed Name:____________________________________ Date:_______________________

Signature:____ Relationship to Client:_________

*I understand that this authorization is voluntary and is not a condition of my treatment or payment.

*I understand that I may revoke this authorization in writing at any time.

*I understand that my information is no longer protected by HIPPA.

*I understand that I may be charged a fee for any medical records associated with this authorization.