Sound Integrated Health
Compassionate & Confidential
Addiction Treatment

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

First Name *

Last Name *

Date of Birth

I, the above named patient, born on the Date of Birth listed above, authorize Sound Integrated Health LLC and its Physicians / clinic staff to:

Check all that apply:

_____ Receive my medical history information from the following physicians:

_____ Receive my treatment records from the following therapists:

_____Release my treatment information / records to the following:

The purpose of this disclosure is: Psychiatric Medication Management

I understand that my records are protected under the Federal regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by the physician / organization specified above, unless I withdraw my consent

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV/AIDS or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipients of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information / records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Today's Date_____ Client Signature_____ DOB _____

Renton
405 S 4th Ave

Tacoma
3640 S Cedar Ste M

Bremerton
4060 Wheaton Way Ste A

Phone 253-478-0827
Fax 253-799-7197

Tacoma@SafeAndSoundRecovery.com