Behavioral Collaborative Care Solutions

9010 SW 137th Ave. Suite 111
Miami, Fl. 33186
Ph: 305-671-3503 Fax: 305-671-3505
Email: info@doctorsccs.com

CONSENT TO RELEASE CONFIDENTIAL REORDS

Please print all information

I, _____, current patient of Behavioral Collaborative Care Solutions, Authorized _____, DOB _____ to have access to my Psychiatric Medical Information, obtain access to speak to Doctors / Therapist regarding my treatment and my illness.

I do NOT / I DO consent to any Mental Medical Care without a Court Order

This authorization is effective from _____ to _____.

_____ _____
Signature of Patient Date

_____ _____
Witness Signature Witness Name (Print)