INTEGRATED
treatment solutions

Authorization to Permit Internet Communication

Name of client: _____

Date of Birth: _____

I understand that the purpose of this release is to permit the transmission of business information electronically between myself and Integrated Treatment Solutions. I also authorize Integrated Treatment Solutions to receive information from such service providers.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer which may be utilized, and I accept these.

The information to be disclosed is marked by an "✔" in the boxes below, and any items not to be released have a line drawn through them:

❑ Name: _____

❑ Address: _____

_____

_____

❑ Home (phone):_____

❑ Cell (phone): _____

❑ Email: _____

❑ Restrictions:

_____

_____

_____

_____

_____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire upon my discharge from treatment by this agency, or under these circumstances:

_____

Signature of client

_____

Printed name Date