Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you Receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected he Health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your Signed authorization. This PHI may include diagnosis, treatment plan, progress and medication if necessary.

I, _____, _____, authorize _____
(Member Name) (Date of Birth MM/DD/YYYY) (Provider Name – Please Print)

to release protected health information related to my evaluation and treatment to:

PCP Name _____ PCP Phone _____
PCP Address _____
(Street) (City/State) (Zip Code)

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____
(Client Name) (Date) (Reason/Diagnosis)
Comments:

If you have any questions or would like to discuss this case in greater detail, please call me at:
Phone Number: _____

_____ _____ _____
(Provider Signature) (Provider Printed Name) (Licensure)

Client Rights

*You can end this authorization (permission to use or disclose information) any time by contacting:
_____.
*If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
*You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
*Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
*You have a right to a copy of this signed authorization. Please keep a copy for your records.
*You do not have to agree to this request to use or disclose your information.

A. Client Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization: PLEASE CHECK ONE

___ To release any applicable mental health / substance abuse information to my primary care physician

___ I DO NOT give my authorization to release any information to my primary care physician

_____ _____ _____ _____
(Client Signature) (Date) (Signature of Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to client: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD
