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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 healthcare. This form allows your Behavioral Health Provider to share Protected Health Information with your PCP. This information will not be released without your signed authorization. This Protected Health Information may include diagnosis, treatment plan, verbal communication and psychological testing/evaluations per your permission.

I, the undersigned, understand that I may revoke this consent at any time. I cannot be required to sign this form as a condition of treatment. I have a right to a copy of the signed authorization. If I make a request to end this authorization, it will not include information that has already been used or disclosed based on my previous permission. I have read and understand the information and give my authorization.

I agree to release the following mental health information to my PCP:

- Diagnosis
- Treatment plan
- Psychological testing/psychological evaluation
- Exchange of mental health and health information

Name, address, phone number and FAX of PCP:

Client signature: _____ Date: _____

Client Name (Print): _____ Date of Birth _____

Guardian signature: _____ Date: _____

Guardian Name (Print) _____

I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services and I direct you NOT to notify my PCP.

Client signature: _____ Date: _____

Client Name (Print): _____ Date of Birth _____

Guardian signature: _____ Date: _____

Guardian Name (Print) _____

Signature authorization is good for one year from signing date.