1320 South Frontage Road, Suite 200
Hastings, MN 55033-2481
651-500-0905
651-437-2616 fax

LutzTherapy.com

2000 Old West Main Street, Suite 300
Red Wing, MN 55066-1993
651-500-0905
651-212-6064 fax

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 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)_____________________________________

________ I agree to have my diagnosis released to my PCP:

Name, address, phone number and FAX of 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.