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 health information (PHI) with your primary Care Physician (PCP). The information will not be released without your signed authorization. This (PHI) may include diagnosis treatment plan progress and medication if necessary.

I, ______________________________ ______________________________ _____/_____/_________
(Patient Name – Please Print) Patient Identification Number (Patient Date of Birth)

Authorize ____________________________ to release protected health information related in my evaluation and treatment to
Provider name – Please Print

PCP Name: ____ **PCP Phone:** ____________________________

PCP Address: ______________________________ ________________________ ___________
(Street) (City) (State) (Zip Code)

Information to be completed by Behavioral Health Provider

I saw ____________________________ on ______________ for____ ____________________________
(Patient Name – Please Print) (Date) (Reason/Diagnosis)

Summary:____

The following medication was/will be started: indicate medication & dosage: ____________________

If no medication is indicated, check as appropriate:

___ Medication not prescribed ___ Patient refused medication ___Psychotherapy suggested before medication

Treatment recommendations:

Lab tests for the following: ___CBC ___Thyroid Studies ___Chem Panel ___EKG
Other treatment recommendations:____
____

If you have questions or would like to discuss this case in detail please call me at: ______________________________
(Phone Number)

______________________________ ______________________________ ____________________
(Provider Signature) (Provider Printed Name) (Licensure)

Patient 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 may be re-disclosed by the recipient and no longer protected by law
- You do not have to agree to this request to use or disclose your information

Patient 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 sis (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

___ To release any applicable mental health/substance abuse information to my primary care physician
___ To release only medication information to my primary care physician
___ I DO NOT give my authorization to release any information to my primary care physician

______________________________ __________ ______________________________ __________
(Patient Signature) (Date) (Signature of Patient/Authorized Representative) (Date)

If signed by Authorized Representative describe relationship to patient: ______________________________