CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. 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, _____ (Patient Name – Print), _____ (Patient d.o.b.) _____ (Patient Social Security #), for the purpose of coordinating care, authorize _____ (Provider Name – Print), to release information indicated in the "Consent" portion of this form to:

PCP Name: _____ **PCP Phone:** _____

PCP Address: _____
(Street) (City) (State) (Zip)

<<<<Provider Complete>>>>

Information For PCP:

The patient was seen by me on (date): _____ for (Diagnosis): _____

Treatment Plan : _____

For Psychiatrists Only:

The following medication(s) was/will be started: (list medications and dosage) _____

_____

___ Medication was not indicated ___ Patient refused medication ___ Psychotherapy suggested before trying med.

___I recommend the following medical intervention by PCP before initiating medications:

Medical work-up for: _____

Lab tests for: ____ CBC ____ Thyroid Studies ____ Chem Panel ____ EKG
Other: _____

Please call me at ( ) _____, to discuss this case further or if you need any other information.

_____
(Provider signature) (Provider Printed Name) (Licensure)

<<<<Patient Complete>>>>

CONSENT

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 consent:

Patient please check one:

( ) 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 consent to releasing any information to my primary care physician.

_____ _____
Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

_____
Witness (Date)

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

PROVIDER: Please Send a Copy of this Signed Form to the Primary Care Physician and Keep the Original in the Patient's Treatment Record