



## AUTHORIZATION TO DISCLOSURE 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 (HI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary.

I, the undersigned understand that I may revoke this consent at any time. I have read and understand the information and give authorization.

### **Patient Authorization** (select the best option)

- I agree to release any applicable mental health/substance abuse information to my PCP.
- I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to so notify him/her.
- I do not have a PCP and do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

Please fill this part if you agreed to release information to your PCP.

My Primary Care Physician is: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

### **Patient Rights**

- You can end this authorization (permission to use or discuss information) any time by contacting our office.
- 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.
- You cannot be required to sign this for as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep a copy for your records. (Ask for your copy at reception).
- You do not have agree to this request to use of disclose information.