AUTHORIZATION TO DISCLOSE HEALTH INFORMATION TO PRIMARY CARE PHYSICIAN

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

## *Patient Authorization*

☐ I agree to release any applicable mental health/substance use disorder information to my PCP.

My primary care physician is _____

Address _____

Telephone Number _____

☐ I agree to release only medication information to the PCP.

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

This authorization will expire on ___/___/_____. If no date entered by patient, this authorization will expire one year from the date of signature below.

_____

Patient Signature Date

## *Patient Rights*

- You can end this authorization (permission to use or disclose information at 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.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep it for your records.
- You do not have to agree to this request to use or disclose information.

*Provider/practitioner: Please send a copy of this signed form to the PCP with the Continuity of Care Consultation Sheet and keep the original in the treatment record.*

Communication between behavioral health providers/practitioners and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. There are circumstances when your behavioral health condition and/or medications will influence treatment of your physical conditions. Many times behavioral health and physical health share a connection. This form will allow your behavioral health provider/practitioner to share protected health information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI will only include diagnosis, treatment plan and medication, if necessary. Information relating to any psychotherapy notes or conversations will not be shared.

REVIEWED 08/23/2018