



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 counselor to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. The PHI disclosed may include diagnosis, treatment plan, updated on progress in treatment, and medication if necessary.

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

PRIMARY CARE PHYSICIAN'S INFORMATION

Physician's Name: _____

Clinic's Name: _____

Address: _____

Phone: () _____ **Fax:** (if known) _____

I agree to release any applicable mental health information to my primary care physician.

I do not want any information released to my primary care physician.

I do not have a primary care physician at this time.

Print Client Name: _____

Client/Guardian Signature: _____ **Date:** _____