AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO PSYCHIATRIST

Communication between Behavioral Health Providers and your psychiatrist 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 psychiatrist. 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:

PSYCHIATRIST'S INFORMATION

Psychiatrist's Name: ______________________________

Clinic's Name: ______________________________

Address: ______________________________

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

☐ I agree to release any applicable mental health information to my psychiatrist.

☐ I do not want any information released to my psychiatrist.

☐ I do not have a psychiatrist at this time.

Print Client Name: ______________________________

Client/Guardian Signature: ______________________ **Date:** ____________