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**Authorization to Disclose Information
To Primary Care Physician**

I understand that my records are protected under the applicable state and federal laws governing health care information that relates to mental health services and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____ hereby authorize _____
(Please Print Client Name) *(Please Print Treating Clinician Name)*

Please Check One of the Following:

- _____ Release any applicable information to my Primary Care Physician
- _____ Do not release information to my Primary Care Physician
- _____ Do not currently have a Primary Care Physician

(Client or Client Responsible Party, please sign) _____
(Date)

(Please print the name signed above)

Primary Care Physician's Name, Address, & Phone

Maintain Original in Client's Behavioral Health File