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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.

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 and Phone Number

_____

_____

_____

10/09