

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and family physicians is important to ensure comprehensive, quality health care. The information to be released is outlined below. This information will not be released without your consent. You may revoke this consent at any time, except to the extent that action has been taken in reliance upon it and that in any event this consent shall be valid for six months from the date signed.

I, _____
(Patient Name) (DOB) (SS#)
for the purpose of coordinating care, authorize _____
(Provider Name)

to release the information indicated on this form below to:

PCP NAME: _____ FAX: _____

PCP PHONE: _____ ADDRESS: _____

INFORMATION FOR PCP:

Your patient was seen by me on _____ Dx: _____

Treatment plan: _____

The following Medication(s) have been Rx: _____

Medication was not indicated Pt refused Medication Psychotherapy suggested before trying Medication

I recommend the following medical intervention by PCP before initiating medication:

Medical work-up for: _____

Lab Test for: CBC Thyroid studies Chem Panel EKG

Other: _____

Please call me at _____ if you have any questions or need any additional information.

(BH Provider Signature)

(Printed Name)

(Date)

CONSENT:

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire six months from the date of signature. I have read and understand the above information and give my consent to the following (please check one):

To release any applicable mental health/substance abuse information to my PCP

To release *only* medication information to my PCP

I *do not* give my consent to release any information to my PCP

(Authorized Signature)

(Relationship)

(Date)