ATTACHMENT 13

Authorization to Disclose information to Primary Care Physician

I understand that my records are protected under applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse patient records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for the extent that action has been taken in reliance on it. This release will automatically expire twelve (12) months from the date signed.

I, ________________________hereby authorize___________________________
Please Print Patients Name Please Print Treating Clinicians Name

Please CHECK ONE:

__________ To release any applicable information to my Primary Care Physician

__________ To release medication information to my Primary Care Physician

__________ NOT to release information to my Primary Care Physician

____ ________________
Patient’s or Patient’s Guardian Signature Date

____ ________________
Please print the name person who signed Date

Primary Care Physicians Name, Address and Telephone Number:
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Note
Behavioral Health Provider must maintain original copy on patient’s file