House Psychiatric Clinic

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. Consent may be revoked at any time except to the extent that the action has been taken in reliance upon it. Consent must be revoked in writing.

I, _____ _____ _____, for the purpose of
(Patient name, printed) (Patient DOB) (Patient SSN)

coordinating care, authorize House Psychiatric Clinic to release information indicated in the "consent" portion of this form to:

PCP Name:_____

PCP Phone:_____

PCP Fax:_____

PCP Address:

_____
(Street) (City) (State) (Zip)

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 upon it. I understand this consent must be revoked in writing. I have read and understand the above information and give my consent: (please circle one)

1. To release any applicable mental health/substance abuse information to my primary care physician.
2. To release only medication information to my primary care physician.
3. I do not give my consent to release any information to my primary care physician.

_____ _____

Patient signature (patients over 18) Parent/guardian signature (patients under 18)

_____

Date