

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____
(Patient's Name) (Patient's ID #)

- Do not have a primary care physician or psychiatrist.
- Have a primary care physician or psychiatrist and you may not contact them.
- Authorize Virginia Felder, to release protected health information related to my evaluation and treatment to my primary care physician or psychiatrist:

Provider's Name: _____ **Provider's Phone:** _____

Provider's Address: _____
(Street) (City) (State) (Zip Code)

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____
(Patient Name – Please print) (Date) (Reason/Diagnosis)

If you have any questions or would like to discuss this case in greater detail, please call me at: (770) 908-0863

Virginia Felder D.Min LMFT (Licensure) GA LMFT #: 000104

Patients Rights

- ❖ You can end this authorization (permission to use or disclose information) any time by contacting Virginia O. Felder at (770) 908-0863.
- ❖ If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- ❖ You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- ❖ Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- ❖ You have a right to a copy of this signed authorization. Please keep a copy for your records.
- ❖ You do not have to agree to this request to use or disclose your information.

Patient Authorization

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 and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

_____ To release any applicable mental health / substance abuse information to my physician.
_____ I DO NOT give my authorization to release any information to my physician.

(Patient Signature)

(Date)

(Signature of Patient's Authorized Rep.) (Date)

If signed by Authorized Representative, describe relationship to patient: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD.