Release of information form
Communication with Primary Care Providers

Authorization to Disclosure Information to
Primary Care Physician

I understand that my records are protected under the 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 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. This release will automatically expire twelve months from the date signed.

I______________________hereby authorize_______________________________
(Please Print Patient's Name) *(Please Print Treating Clinician's Name)*

Please check one:

______To release any applicable information to my Primary Care Physician
______To release medication information only to my Primary Care Physician
______Not to release information to my Primary Care Physician

____ _________________
(Parent's or Patient's Guardian, please sign) ***(Date)***

____ _________________
(Please print the name signed above) ***(Date)***

Primary Care Physician's Name, Address & Phone:

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Note to Behavioral Health Care Provider:
Please maintain original copy in patient's file