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# Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization.

**Section 1 The Patient.**

| Last Name | First Name | | Middle Initial |
|---|---|---|---|
| Subscriber Number From ID Card | Insurance Company Name | Date of Birth | Phone Number |

I hereby authorize the disclosure of protected health information about the individual named above.
__I am the individual named above (complete (Section 8 below to sign this form)
__I am a personal representative because the patient is a minor, incapacitated, or deceased (complete Section 9 below)

**Section 2 Who Will Be Disclosing Information About the Individual?**

The following Behavioral Health provider may disclose the information:

| Name (a person, or organization if you are naming a practice) | Phone Number (if known) |
|---|---|

**Section 3 Who Will Be Receiving Information About the Individual?**

This information may be disclosed to the following primary care physician:

| Name (a person, or organization if you are naming a practice) | Phone Number (if known) |
|---|---|
| Street Address (if known) | City, State and Zip Code (if known) |

**Section 4 What Information About the Individual Will Be Disclosed?**

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis and medication(s) if necessary.

**Section 5 The Purpose of the Disclosure.**

The purpose is to release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

**Section 6 The Expiration Date or Event.**

This authorization shall expire one (1) year from the date of signature below unless revoked prior to that date.

**Section 7 Important Rights and Other Required Statements You Should Know**

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment or treatment for services.
- This authorization is completely voluntary and you do not have to agree to authorize any use or disclosure.
- You have a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

**Section 8 Signature of the Individual**

Signature_____ Date (Required)_____

**Section 9 Signature of Personal Representative (if applicable)**

Signature_____ Date (Required)_____

## NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.