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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. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

I, ________________________________ , ____________________________, ____________________________________
(Patient Name – Please Print) (Patient Identification number) (Patient Date of Birth – MM/DD/YYYY)

authorize Elizabeth T. Rieger, to release protected health information related to my evaluation and treatment to:

PCP Name: ________________________________ **PCP Phone:**____

PCP Address: ____________________________________ ______________________ ______ ____________
(Street) (City) (State) (Zip Code)

Information to be completed by Behavioral Health Provider

I saw __________________________________ on ____________________ for__________________________________
(Patient Name) (Date) (Reason/Diagnosis)

Summary:
____

____

Other treatment recommendations: ____

If you have any questions or would like to discuss this case in greater detail, please call me at: 937-203-8141.

___________________________ ________________________________ _________________________
(Provider Signature) (Provider Printed Name) (Licensure)

Patient Rights

You can end this authorization (permission to disclose information) any time by contacting Elizabeth T. Rieger at, 937-203-8141.
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 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 6 months from the date of signature, unless another date is specified. I have read and understand the above information

Please Check <u>One</u>

______To release any applicable mental health/substance abuse information to my PCP.
______ To release only medication information to my primary care physician.
______ I DO NOT give my authorization to release any information to my PCP.

____________________________________ ________________ ________________________________ ____________
(Patient Signature) (Date) (Patient's Authorized Representative Signature) (Date)

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