# PSYCHOLGICAL STRATEGIES, LLP

## Authorization to Disclose Information to Primary Care Physician

***<u>Note: Complete top section to allow release of information; bottom section to deny consent</u>***

**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 in twelve (12) months from the date signed.**

I, ___________________________________ hereby authorize __________________________
*(Please Print Patient's Name)* *(Please Print Treating Clinician's Name)*

To release the following information to my Primary Care Physician: (Please initial each item if consent is given):

____ Dates of Service, symptoms, diagnosis
____ Treatment Progress
____ Psychotherapy Notes
___ Treatment Plan
___ Test Results
___ Other_____________________

_______________________________________
*(Signature of Patient or Patient's Guardian)*

_________________________
*(Date)*

_______________________________________
*(Please print the name signed above)*

_________________________
*(Witness)*

**Primary Care Physician's Name, Address & Phone**

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

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I, __________________________________________ hereby refuse consent for the release of my records to my primary care physician.

__________________________________________
*(Signature of Patient or Patient's Guardian)*

______________________________
*(Date)*

_________________________________________
*(Please print the name signed above)*

_______________________________
*(Witness)*

**Patient Name:** ____________________________ **Patient ID:** ____________________