Behavioral Health Choices

Consent to Release Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medications. I may revoke this consent at any time except to the extent that the action has been taken in reliance up on it and that in any event this consent shall expire 12 months from the date of signature, unless another date has been specified.

I, _______________________ ______________ for the purposes of coordinating care,
Patient's Name-print Patient D.O.B:

Authorize Behavioral Health Choices to release information indicated in the "consent" portion of this form to

PCP Name:____
PCP Address:____
____
PCP Phone:________________________________

Consent

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 12 months from the date of signature unless another date is specified. I have read and understood the above information and give my consent.

Please check the following:
__to release any applicable mental health/substance abuse information to my primary care physician

____
Patient's Signature (patients over 18 years) Date

____
Parent/Guardian Signature (patients under age 14) Date

____
Witness Date

Behavioral Health Choices