CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians 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 medication if necessary. I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date has been specified.

I, _____ _____ _____ . For the purpose of coordinating care,
(patient name-print) (pt D.O.B.) (pt. Social Security #)

Authorize _____, to release information indicated in the "consent" portion of this form to:

PCP Name: _____

PCP Phone: _____ **PCP Fax**_____

PCP Address:_____
(Street) (City) (State) (Zip)

Information for PCP

The patient was seen by me on (date)_____ for (Diagnosis): _____
Treatment Plan_____

For Psychiatrists Only

The following medication(s) was/will be started (list medications and dosage)_____

____ Medication was not indicated ____ Patient refused medication ____Psychotherapy suggested before trying med.

____ I recommend the following medical intervention by PCP before initiating medications:
Medial work-up for: _____

Lab tests for: ____ CBC _____ Thyroid Studies _____Chem Panel _____ EKG
Other:_____

Please call me at (215/ 947-8654) ext: ____, to discuss this case further or if you need any other information.

_____
(Provider Signature) (Provider Name) (Licensure)

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 six (6) months from the date of signature, unless another date is specified. I have read and understood the above information and give my consent:

PATIENT PLEASE CHECK ONE OF THE FOLLOWING !!!!!!!

1) ☐ To release any applicable mental health/substance abuse information to my primary care physician.
2) ☐ To release only medication information to my primary care physician.
3) ☐ I do not give my consent to releasing any information to my primary care physician.

_____ _____
Patient signature (patients over 18) (Date) Parent/Guardian Signature (patients under 18) (Date)

_____
Witness (Date)

** For Clinician please attach Business Card**