AUTHORIZATION 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 medication if necessary. You 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 months from the date of signature, unless another date has been specified.

I, _____________________________, _____________ , for the purpose of coordinating care, authorize Growth
(Patient Name) (Patient DOB)
Opportunity Center, to release information indicated in the "consent" portion of this form to:

PCP Name: ____

PCP Phone: _________________________________ **PCP Fax:**__________________________________

PCP Address: ____

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 ____
____

___Medication was not indicated ___ Patient Refused Medication ___Psychotherapy suggested before trying Medication

___I recommend the following medical intervention by PCP before initiating Medications:
Medical 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)

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 months from the date of my signature, unless another date is specified. I have read and understood the above information and give my consent verbally or in writing:

PATIENT: PLEASE CHECK ONE OF THE FOLLOWING:

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

_______________________________ ___________ _______________________________ __________
Patient Signature (Patient over 18) Date Parent/Guardian Signature Date

_______________________________ ___________
Witness Date