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 Deborah Baldwin MS LPCC to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plans, progress, and medication if necessary.

I, _____, _____, _____/_____/_____,
(Patient Name-Please Print) (Patient Identification Number) (Patient Date of Birth –MM/DD/YYYY)

authorize Deborah Baldwin MS LPCC, to release protected health information related to my evaluation and treatment to:

Primary Care Physician (PCP): _____ **PCP Phone**:_____

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

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____
(Patient Name – Please Print) (Date) (Reason / Diagnosis)

Summary:_____

_____

If no medication is indicated, check as appropriate:

_____ Patient declines medication _____ Psychotherapy suggested before trying medication

Treatment recommendations: _____

_____

If you have any questions or would like to discuss this case in greater detail, please call me at: (937) 431-5035

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

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting:

Deborah Baldwin MS LPCC in writing at 2365 Lakeview Dr Ste B, Beavercreek, OH 45431

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

PATIENT PLEASE CHECK ONE

_____ To release any applicable mental health / substance abuse information to my primary care physician.

_____ To release only medication information to to my primary care physician.

_____ I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

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

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.