A Better Way Counseling Service, LLC

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Authorization to Disclose Health Information to Primary Care Physician

Coordination between behavioral health providers and your primary care physician (PCP) is an option to ensure that you receive comprehensive and quality health care. There are circumstances when your behavioral health condition and/or medications will influence treatment of your physical conditions. Many times behavioral health and physical health share a connection. This form will give you the option to allow your behavioral health provider to share protected health information (PHI) with your PCP. This information **will not** be released without your signed authorization. This PHI will only include diagnosis, treatment plan and medication, if necessary. Information relating to any psychotherapy notes or conversations will **not** be shared.

I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization.

Client Authorization: (please initial the option that applies)

_____ **I agree** to release any applicable mental health/substance abuse information to my PCP

- Primary Care Physician name:_____
- Address _____
- Telephone Number _____

_____ **I waive** notification of my PCP that I am seeking or receiving behavioral health services and I direct you NOT to notify him/her.

_____ **I do not have** a PCP and do not wish to see or confer with such an individual. I, therefore, WAIVE NOTIFICATION of a PCP that I am seeking or receiving behavioral health services.

Client Printed name: _____ Date: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Client Rights:

- You can end this authorization (permission to use or disclose information at any time) by contacting your counselor.
- 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.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization. Please keep it for your records.
- You do not have to agree to this request to use or disclose information.