

## **Primary Care Physician Consent Form**

Communication with your primary care prove This form allows for that exchange of inform			
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Name		SS Number or ID Num	mber D.O.B
Insurance		First Date of Service	
Name of Physician		Facility/Practice Address	
Phone Number		Fax Number	
I,	Client Please Check One:		
(PRINT Name of Patient/Client)	☐ Do <u>NOT</u> release any applicable information to my primary care physician.		
	☐ Release a	pplicable information to my prima	ary care physician.
Signature of Client			Date Signed
OR			
I/We,		on behalf of,	
(PRINT Name of Parent(s)/Legal	Guardian(s))	(PRINT N	Vame of Child)
	Parent or Legal Guardian Please Check One:		
	□ Do <u>NOT</u> re	elease applicable information to th	ne child's primary care physician.
	☐ Release appli	icable information to the child's p	rimary care physician.
Signature of Parent or Legal Guardian	Signatur	e of Parent or Legal Guardian	Date Signed

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, 45 C.F.R. parts 160 & 164 and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), and any further disclosure for the purpose of treatment, payment, or health care operations, if permitted by state law. I understand that I may be denied services if I refuse to consent to a disclosure for other purposes. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described above with the people and/or organizations named above. I have read this release and understand its contents. I also understand that I may revoke this consent at any time by notifying the provider in writing (except to the extent that action has already been taken in reliance on it). This release will automatically expires twelve months from the date signed below or upon the date specified here.