Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between you and your behavior health provider(s) and your primary care physician (PCP) is important to make sure all is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your authorization. Once completed and signed, please give this form to your behavioral health provider.

Section 1. The Patient

- I hereby ☐ ***authorize*** ☐ ***do not authorize*** (circle one) the disclosure of protected health information about the individual named above.
- I am (check one):
  - ☐ The individual named above (*complete Section 8 below to sign this form*)
  - ☐ A personal representative because the patient is a minor, incapacitated, or deceased (*complete Section 9 below*)

Section 2. Who Will Be Disclosing Information About the Individual?

The following behavioral health provider may disclose the information:
Freedom Counseling Center, Inc.
1901 Niles Ave. Suite 102
Saint Joseph, MI 49085
269-982-7200

Section 3. Who Will Be Receiving Information About the Individual?

The information may be disclosed to the following primary care physician:

- Name (a person or an organization if you are naming a facility) _____ Phone Number (if known) _____
  Street _____ City, State, and Zip Code _____

Section 4. What Information about the Individual Will be Disclosed?

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

Section 5. The Purpose of Disclosure

To release behavioral health evaluation and/or treatment information to the PCP to ensure quality and coordination of care.

Section 6. The Expiration Date of Event

This authorization shall expire 1 year from the date of the signature below unless revoked prior to that date. _____

Section 7. Important Rights and Other Required Statements You Should Know

- You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have the right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by contacting your behavioral health provider named above.

Section 8. Signature of the Individual

- Signature _____ Date (required) _____

OR

Section 9. Signature of Personal Representative (if applicable)

- Signature _____ Date (required) _____
  Relationship to the individual (required) _____

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentially 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 patients (42 CFR Part 2), a general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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