SAMARITAN counseling center

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

PART 1: ***Primary Care Physician***

Name of Physician: _____

Mailing Address: _____

_____

City State Zip Code

I grant permission for my therapist to release to my Primary Care Physician dates of service, as well as diagnostic and treatment information (please select one)**:** **____ YES ____ NO**

PART 2: ***Referring Professional***

Name of Referring Professional: _____

Mailing Address: _____

_____

City State Zip Code

I grant permission for my therapist to release to my Referring Professional that I made my first appointment (please select one)**:** **____ YES ____ NO**

Client Name (printed): _____ **Date of Birth**: _____

_____

Signature **Date**

We are here to help.