Authorization to Disclose Information to
Primary Care Physician (PCP) and Referring Professional

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.

Primary Care Physician (Please print)

Name of PCP ____

Mailing Address: ____

____

____
City State Zip

I grant permission for my therapist: (please select yes or no)

Yes ❑ No ❑ To release to my Primary Care Physician dates of service and diagnostic and treatment information.

Referring Professional (Please print)

Name of referring professional ____

Mailing Address: ____

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____
City State Zip

I grant permission for my therapist: (please select yes or no)

Yes ❑ No ❑ To release to my referring professional that I made the first appointment.

____
Printed Name of Client

_______________________________ _______________________
Signature of Client/Guardian Date