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PROVIDER COMMUNICATION RELEASE

Patient Information

Patient Name	**Date of Birth**

Primary Care Provider Information _____ **I do not have a Primary Care Provider**

Medical Provider Name	**Phone Number**
Address	**Fax Number**

Psychologist or Therapist Information _____ **I do not have a therapist or psychologist**

Name	**Phone Number**
Address	**Fax Number**

Patient Rights

- You can end this authorization (permission to use or disclose information) at any time by contacting this office.
- 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 consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this authorization form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization:

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall be valid as long as I am a patient with the practice, unless another date is specified. I have read and understand the above information and give my authorization.

Please check one:

I agree to release:

_____ any applicable mental health/substance abuse information to my medical provider or therapist

_____ only medication information to my medical provider or therapist

_____ I do not give my authorization to release any information to any provider.

Patient Signature: _____ **Date**: _____