

Authorization to Disclose Protected Health Information to your Primary Care Physician

Communication between your therapist and your primary care physician (PCP) is important to ensure that you receive quality comprehensive healthcare. By signing this form you give your therapist permission to share protected health information with your primary care physician. This information may include diagnosis, treatment plan, and your progress. We will not release any information without your written permission.

I, _____
(Patient Name) (Date of Birth)

authorize my therapist _____ Thomas S. Freeman, PsyD to release protected health information related to my evaluation and treatment to:
_____ Laura Thompson, PhD
_____ Janet Gaffney, PhD
_____ Joseph Adams, LPC
_____ Pamela Cook, LPC
_____ Glenda Boyd, PsyD
_____ Zane Scarborough, PhD
_____ Erin Wisheart, LMFT

Physician's name _____ Phone # _____

Address: _____
(Street) (City) (State) (Zip)

To be completed by therapist

Dr. _____, I saw _____ on _____
(Patient Name)
_____ for _____
(Date) (Reason/Diagnosis)

Impressions: _____

Please feel free to call me at (770) 251-5873 to discuss this further. **(This is not a request for medical records.)**

_____ Thomas S. Freeman, PsyD
_____ Laura Thompson, PhD
_____ Janet Gaffney, PhD
_____ Joseph Adams, LPC
_____ Pamela Cook, LPC
_____ Glenda Boyd, PsyD
_____ Zane Scarborough, PhD
_____ Erin Wisheart, LMFT

(Provider Signature)

Patient Rights

- ❖ You can end this authorization (permission to use or disclose information) any time by contacting your therapist.
- ❖ 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 permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- ❖ 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 action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

(PATIENT PLEASE CHECK ONE)

_____ To release any applicable mental health/substance abuse information to my primary care physician.
_____ I DO NOT give my authorization to release any information to my primary care physician.

(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: _____

This information has been disclosed to you from records the confidentiality 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 patient records (42 CFR Part2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 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 in 1991.