**Authorization To Release Information (PCP)**

**Information may be provided between:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**And Primary Care Physician(PCP):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- |
| https://ww2.crediblebh.com/images/spacer.gif**For the Purpose of:** |
| https://ww2.crediblebh.com/images/spacer.gif

|  |  |  |  |
| --- | --- | --- | --- |
| spacer |  | spacer | Evaluation and Treatment |
| spacer |  | spacer | Coordinating Treatment |
| spacer |  | spacer | Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |

**Between the dates of:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Nature of Information to be Disclosed:**



|  |  |  |  |
| --- | --- | --- | --- |
| spacer |  | spacer | History and Physical |
| spacer |  | spacer | Discharge Summary |
| spacer |  | spacer | Treatment Plan |
| spacer |  | spacer | Court/Legal Records |
| spacer |  | spacer | Educational Report |
| spacer |  | spacer | Progress Notes |
| spacer |  | spacer | Psychological Evaluation |
| spacer |  | spacer | Mental Health Records |
| spacer |  | spacer | Lab Reports/Medication Records |
| spacer |  | spacer | Consultations |
| spacer |  | spacer | Social History |
| spacer |  | spacer | Drug Abuse Records \_\_\_\_\_\_\_\_\_(initial) |
| spacer |  | spacer | Alcohol Abuse Records\_\_\_\_\_\_\_\_ (initial) |
| spacer |  | spacer | HIV Records \_\_\_\_\_\_\_ (initial) |
| spacer |  | spacer | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

This consent for disclosure of information whose confidentiality is protected by federal laws includes special authorization to release medical information under the drug abuse office and treatment act of 1972 (P.L. 92-255) and the comprehensive alcohol abuse and alcoholism prevention, treatment and rehabilitation act amendments of 1974 (P.L. 93-282).

I certify that this request has been made freely, voluntarily and without coercion and that the information specified above is true and correct to the best of my knowledge. I authorize and consent to the disclosure by and to the above named facility and/or persons of information, records, documents, reports, clinical abstracts, histories and charts relating to my condition, care and treatment and consent to furnishing photostatic copies of same. I understand that I may revoke this consent at any time, except to the extent that action has already been taken to comply with it. This consent will automatically expire 90 days after the termination of treatment at PSA, unless I execute a written revocation at an earlier date

Re-disclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent. ANY REDISCLOSURE OF RECORD INFORMATION BY THE RECIPIENT OF THIS CONSENT IS PROHIBITED

Client Signature:

Date/Time:

Staff Signature:

Date/Time: