MONARCH BEHAVIORAL HEALTH ASSOCIATES

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physician is important to help insure you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress and medication if necessary. This consent may be revoked at any time except to the extent that action has been taken in reliance upon it. This consent shall expire with the termination of MBHA services, unless otherwise specified.

I, ____ ______________________________, for the purpose of coordination of care,

(Patient Name) (Patient DOB)

Authorize ____ to release information indicated below to:

PCP Name:____

PCP Phone:____

PCP Address:____

Information for PCP

The patient was initially seen on ______________________ for the treatment of ____

Date (ICD-10 Diagnosis)

Care is being delivered in an outpatient setting. The treatment plan consists of the following modalities:

_____ Individual Psychotherapy
_____Couple/Marital Psychotherapy
_____Family Psychotherapy
_____Group Psychotherapy

Please call me at ______________________________if further information is needed.

Sincerely,

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I hereby authorize to disclose to my PCP, noted above, all clinical information about me as may be necessary to permit my PCP to monitor the continuity of my care. This authorization becomes effective from the date of signature below and may be revoked at any time, except to the extent of action already taken. Unless revoked, this authorization automatically terminates upon termination of services from MBHA. It is also understood that the information authorized by the release will be released to the authorized recipient only for the purpose noted above. It is understood that the patient (or legal representative) is entitled to a copy of this authorization form.

____ ____

Signature of Patient or legal Guardian Date Witness Date

Name Of Patient (Please Print) ____