

LIFE CHOICES ONLINE

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE DOCTOR

Communication between behavioral health providers and your primary care physician is needed to verify any mental health prescriptions they may be providing for a diagnosed condition. This information will not be released without your consent. The information may include diagnosis, progress, and medications. 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 in one year from the date of signature unless another date is specified.

I, _____, _____, for the purpose of coordinating
Patient Name Patient D.O.B

care, authorize, Life Choices Online, to release information indicated in the "Consent"
provider name-print
portion of this form to:

PCP Name: _____

PCP Phone: _____ fax: _____

PCP Address: _____

The patient was seen by me on (date) _____ for (Diagnosis) _____

FOR PSYCHIATRIST ONLY

The following medication(s) was/will be started: (list medications/dosages) _____

Please indicate the following: ___ Medication was not indicated ___ Patient refused medication ___ Therapy suggested before trying medications. ___ I recommend the following medical evaluation by PCP before initiating medications: Medical work-up for: _____

Lab Tests for: ___ CBC ___ Thyroid Studies ___ Chem Panel ___ EKG ___ Other: _____

Please call me at () _____, to discuss any further information required.

Provider Signature: _____

Printed Name and Licensure: _____

CONSENT

I, the undersigned, understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance upon it. I have read and understand the above information and give my consent:

___ To release any applicable mental health/substance abuse information to my primary care physician.

___ To release only medication information to my primary care physician.

___ I do not give consent to releasing any information to my primary care physician.

Patient Signature: _____ (over 18 yrs of age)

Witness: _____

Notice to recipient of this information: This information has been disclosed to you from records which are protected by federal (42, CFR, Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose

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AUTHORIZATION FORM

I, _____, _____,
Patient Name **Birth date**

This Authorization form, when completed, signed and dated by you, authorizes us to release or receive protected information from your clinical record to/from the person you designate.

I authorize _____ and/or his/her staff to
___ Release to ___ Receive from:

The following: (provide detailed description of information): _____

I am requesting to release this information for the following reasons: ("at the request of the patient") is all that is required if you are the patient and you do not desire to state a specific purpose.)

This authorization will remain in effect for one year or until: _____
I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.
___ I do want a copy of this information sent electronically or via the internet ___ I want a copy of this form, please print a copy for your records.

CONSENT

I, the undersigned, understand that I may revoke this consent at anytime except to the extent that action has been taken in reliance upon it. I have read and understand the above information and give my consent:
___ To release any applicable mental health/substance abuse information to my primary care physician.
___ To release only medication information to my primary care physician.
___ I do not give consent to releasing any information to my primary care physician.

Patient Signature: _____ (over 18 yrs of age)

Witness: _____

Notice to recipient of this information: This information has been disclosed to you from records which are protected by federal (42, CFR, Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose