



Release of Information and Coordination of Care between Health Care Providers

Communication between behavioral providers and your primary care physician (PCP), and other behavioral health providers is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This PHI may include diagnosis, treatment plan and/or progress.

Client Rights

- You may end this authorization at any time in writing by sending a notification to North Phoenix Counseling, LLC at the address listed on the top of this form.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- Unless court ordered, if you choose not to agree with this request, your benefits, treatment, or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing.

It is understood that after my information is disclosed to another person or company, it may not be protected by the federal privacy rule, could possibly be relayed to someone else, and may no longer be protected by federal HIPAA privacy regulations. **This consent expires in twelve (12) months from the date of my signature below unless otherwise stated.**

North Phoenix Counseling, LLC is authorized to release protected health information related to the evaluation and treatment of _____ / _____ / _____.
(Client Name) (Date of Birth – MM/DD/YYYY)

May we coordinate care with your Primary Care Provider (PCP)? Yes No

PCP Name: _____ Company: _____

PCP Phone: _____ PCP Fax: _____

May we coordinate care with your previous or additional Behavioral Health provider ? Yes No

BH Provider Name/ Company: _____ Company: _____

PCP Phone: _____ PCP Fax: _____

May we coordinate care with any others you would like involved in your treatment? (family, friends, clergy, etc.) Yes No

Other Name: _____ Phone: _____

Other Name: _____ Phone: _____

Disclosure may include the following verbal or written information: (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History & physical | <input type="checkbox"/> Laboratory/diagnostic testing results | <input type="checkbox"/> School information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Medication records | <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychological eval/testing results |
| <input type="checkbox"/> ER record report | <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Summary of Treatment Records | <input type="checkbox"/> Custody Reports |
| <input type="checkbox"/> Substance abuse record | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Coordination of Care | <input type="checkbox"/> Other |

 (Signature of Patient, Parent, Guardian or Authorized Representative)

 (Date)