PATIENT COMPLETE

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that 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. 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, _____ _____ _____ , for the purpose of coordinating

(Patient name – Print) (Patient d.o.b.) (Patient Social Security #)

care, authorize _____ to release information indicated in the "Consent" portion of this form to:

(Provider Name – Print)

PCP Name: _____

PCP Phone: _____ **PCP Fax:** _____

PCP Address: _____

(Street) (City) (State) (Zip)

Provider complete

Information for PCP:

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

Treatment Plan : _____

For Psychiatrists Only:

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

_____

_____ Medication was not indicates _____ Patient refused medication _____ Psychotherapy suggested before trying medication

_____ I recommend the following medical intervention 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 this case further or if you need any other information.

_____ Robert J Jann PhD Suite 216 – 6 Penns Trail Newtown PA 215-378-0471 Psychologist PS004443L

(Provider Signature) (Provider Printed Name) (Licensure)

CONSENT

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 consent

Patient please check one:

( ) 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 my consent to releasing any information to my primary care physician.

PATIENT COMPLETE

_____ _____

Patient signature (Patients over 18) Date **Parent/Guardian Signature (Patients under 18) Date**

_____

Witness (Date)

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.

PROVIDER: Please Send a Copy of this Signed Form to the Primary Care Physician and Keep the Original in the Patient's Treatment Record.