Cruson Counseling Center

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Certified Child-Centered Play Therapist *EMDRIA Trained EMDR Clinician*

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COORDINATION OF CARE BETWEEN HEALTHCARE PROVIDER/RELEASE OF INFORMATION

Communication between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and facilities is important to ensure you receive comprehensive, quality health care. This form will allow your BHC provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medications.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have 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.
- If you choose not to agree with this request, your benefits 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 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 understand I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

_____is authorized to release protected health information related to the evaluation and treatment

of _____ _____ ____/____/_____
(Client's Name) (Client's Member ID#) (Client's Date of Birth)

PCP Name: _____ PCP Phone: _____
PCP Address: _____ _____
(Street) (City) (State) (Zip Code)

Other BH Provider Name: _____ BH Provider Phone: _____
BH Provider Address: _____ _____
(Street) (City) (State) (Zip Code)

Other Name: _____ Other Phone: _____
Other Address: _____ _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply):
__Face sheet __History and physical __Laboratory/diagnostic testing results __School information __ER record report __Discharge summary __Medication records __Behavioral health/psychological consult __Psychiatric evaluation __Psychological eval/testing results __Psychosocial assessment __Substance abuse treatment record __Summary of treatment records/contact dates __Other

___ I hereby refuse to give authorization for any release of information

_____ _____
Signature of Patient, Parent, Guardian, or Authorized Representative Date
If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e., Power of Attorney, Living Will, or Guardianship papers, etc.).