Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

PATIENT CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _______________________________(patient name) give permission to ____________________________ (Behavioral Health Provider) and my Primary Care Physician ______________________________________ (Primary Care Physician) to share information about my diagnosis and/ or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

____ ________________________________

Patient, Parent or Legal Guardian Signature Date

____ ________________________________

Witness Signature Date

Member Refusal to Release Confidential Information

I, ____________________________(patient name) DO NOT give permission to _________________________ (Behavioral Health Provider) and my Primary Care Physician ______________________________________ (Primary Care Physician) to share information about my diagnosis and/ or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

____ ________________________________

Patient, Parent or Legal Guardian Signature Date

____ ________________________________

Witness Signature Date

This consent becomes effective on the date of signing and I can choose to cancel it at any time.