Authorization to Disclose Protected Health Information to Primary Care Physician

ommunication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality alth care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This formation will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

_______________ _______________ _______________ , ____/____/____
(Member Name) (Member Identification Number-optional) (Subscriber Identification Number) (Date of Birth-MM/DD/YYYY)

authorize _______________________ , to release protected health information related to my evaluation and treatment to:
(Provider Name – Please Print)

PCP Name: _______________________ **PCP Phone:** _______________

PCP Address: _______________ _______________ _______ _______________
(Street) (City) (State) (Zip Code)

Information to be completed by Behavioral Health Provider

saw _______________ on _______________ for _______________
(Patient Name – Please Print) (Date) (Reason / Diagnosis)

f you have any questions or would like to discuss this case in greater detail, please call me at: _______________
(Phone Number)

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

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting:

____

- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

, 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 authorization: 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 authorization to release any information to my primary care physician.

_______________ _______________ _______________ _______________
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

f signed by Authorized Representative, describe relationship to patient: _______________

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

is information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly mitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is

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CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

Patient Name ________________________________

Federal regulations (HIPAA) allow me to use or disclose Protected Health Information (PHI) from your record in order to provide treatment to you, to obtain payment for the services we provide, and for other professional activities (known as "health care operations."). Nevertheless, I ask your consent in order to make this permission explicit. The Notice of Privacy Practices describes these disclosures in more detail. You have the right to review the Notice of Privacy Practices before signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time. If we do so, the revised Notice will be posted in the office. You may ask for a printed copy of our Notice at any time.

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be disclosed for treatment, payment, or health care operations; however, we do not have to agree to these restrictions. If we do agree to a restriction, that agreement is binding.

You may revoke this consent at any time by giving written notification. Such revocation will not affect any action taken in reliance on the consent prior to the revocation.

This consent is voluntary; you may refuse to sign it. However, we are permitted to refuse to provide health care services if this consent is not granted, or if the consent is later revoked.

I hereby consent to the use or disclosure of my Protected Health Information as specified above.

Signature of Patient: ________________________________ Date: __________

The Zenter
Clients' Rights and Responsibilities Statement

Statement of Clients' Rights

Clients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Their treatment and other client information kept private. Only where permitted by law, may records be released without client permission.
- Easily access timely care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by the client's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- Information about the Zenter, its practitioners, services and role in the treatment options.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Clients' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complain or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Clients' Responsibilities

Clients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the client and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including modifications given to them by others.
- Keep their appointments. Clients should call their provider(s) as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

____
Client Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the client a cop of this form.

____
Provider Signature Date

Case Number: