Holly Maddy, LLC
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Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) 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 with your PCP. This information will not be released without your signed authorization. This information may include diagnosis, treatment plan, progress and medication if applicable.

I ,(Patient Name) _____ , (Date of Birth) _____ ,
Authorize Holly A. Maddy, LLC, to release protected health information related to my evaluation and treatment to:

PCP Name:	PCP Phone:	PCP Fax:	
PCP Address:	City:	State:	Zipcode:

Information to be completed by Behavioral Health Provider:

The above patient was first treated on: for (reason/diagnosis):
Summary:
Signature:
If you have any questions or would like to discuss this case in greater detail, please contact the provider at (859) 431-6333: ☐ Holly Maddy MSW, LCSW, LISW-S(ext. 2) ☐ Stefani McElheney MSSW, LMFT (ext. 3) ☐ Mark Switzer MSW, LCSW, LISW (ext. 5)

- You can end this authorization (permission to use or disclose information) any time by contacting your therapist: Holly Maddy (859) 431-6333 ext. 2, Stefani McElheney ext. 3, Mark Switzer ext. 5
- 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.
- 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 do not have to agree to this request to use or disclose your information.

Patient Authorization

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 (12) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization:

____ To release any applicable mental health/substance abuse information to my primary care physician.

____ I DO NOT give my authorization to release any information to my primary care physician.

Patient Signature	Signature of Patient's Authorized Representative	Date

This information has been disclosed to you from record the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patent records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted 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 NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.