# AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION
# WITH PRIMARY CARE PROVIDER

Patient Name:_____ DOB:_____

Information to be released by or exchanged with:_____

_____

Information to be received by or exchanged with Sullivan Mental Health Services for the purpose of treatment.

Information to be released or exchanged:

□ Mental Health Assessment

□ Treatment Plans

□ Substance Abuse Assessment

☒ HISTORY AND PHYSICAL EXAM ☒ COORDINATION OF CARE

□ Discharge Summary

□ Medical Records

□ Diagnosis

□ Progress Notes

□ Other:_____ _____

This authorization will expire in 1 year unless another date or event is specified here:_____

*I understand that, at my request, a copy of the completed and signed authorization form will be made available to me. I understand that I may revoke this authorization in writing, at any time, except to the extent that action has been taken in reliance upon this authorization. I may submit my written statement of revocation to Sullivan Mental Health Services. I understand that the person or entity who receives my information may not be required to prevent unauthorized use or disclosure.*

*I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of my treatment including testing and or treatment for sexually transmitted diseased, AIDS, or HIV infection, alcohol and or drug abuse and mental health conditions.*

*I understand that my signature is not required for treatment or payment, and that a copy of this authorization shall be as valid as the original.*

Signature:_____Date:_____

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I do **NOT** wish to allow Sullivan Mental Health Services to share my information or request information from any other providers at this time.

*I have had the benefits and risks of not signing this release explained to me and I understand this decision.*

Signature:_____Date:_____

AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

# WITH PRIMARY CARE PROVIDER

Staff Signature:_____Date: _____