Behavioral Health Associates

Coordination of Care between Health Care Provider and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities 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 (PHI) with your other provider. This information will not be released without your signed authorization. This PHI includes diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make request to end this authorization, it will not include information that may have 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 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/substance abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that 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 also understand that 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 This consent will remain in effect until it is rescinded.

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

Patient _____ DOB _____ Male _____ Female _____

This authorization allows Ronnie J Evans, MS, LMHC, NCC (to release/to obtain) protected health information (to/from)
Provider Name-Please Print

_____ _____ _____
Primary Care Physician | Phone # | Fax #

_____ _____ _____
Address | City, State | Zip Code

X_____ _____
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.)

_____
Witness