Melissa Shane Counseling Services LLC

**Authorization to Disclose Protected Health Information to Primary Care Physician**

Communication between Behavioral Health Providers and your Primary Care Physician/Provider (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider (Melissa Shane, LCPC), to share Protected Health Information (PHI) with your PCP. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, and medication if necessary. I, the undersigned, understand that I may revoke this consent at any time. I have read and understand the information and give my authorization:

**Patient Authorization**

**\_\_\_** I agree to release any applicable mental health/substance abuse information to my PCP. This includes substance abuse and HIV status.

My Primary Care Physician/Provider is:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Limitations to information allowed to be shared:

**\_\_\_** I WAIVE NOTIFICATION of my PCP that I am seeking or receiving mental health services, and I direct you NOT to notify him/her.

**\_\_\_** I do not have a PCP and I do not wish to see or confer with one. I therefore WAIVE NOTIFICATION of a PCP that I am seeking or receiving mental health services.

**\_\_\_**  My signature below indicates that I understand disclosure of PHI (Protected Health Information) can and will be released to my PCP by mail, email, telephone or direct contact. If authorized, I also understand that Melissa Shane, LCPC, will mail periodic updates to my PCP.

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent or Guardian Signature if client under age 12: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Rights:**

• You can end this authorization (permission to use or disclose information) any time by contacting: Melissa Shane, LCPC, in writing.

• 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.

• You cannot be required to sign this form as a condition of treatment, payment, or enrollment or eligibility for benefits.

• 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 of disclose information