**Behavioral Health and Wellness Associates**

**of Northern Virginia**

4460 Brookfield Corporate Drive Suite H

Chantilly, VA 20151

(571) 261-8239 / Fax: (571) 933-6506

Primary Care Physician Release of Information

It is often necessary to consult with physicians and nurse practitioners regarding medical/medication issues pertaining to our clients to insure the highest quality of care. As a result it is helpful to have a signed release of information to your primary care physician (PCP) or nurse practitioner. In today’s world, it is typically the role of the PCP to be aware of all treatment you or your child receive to help insure proper coordination of care. The treating clinician often needs to make sure your PCP is aware of any referrals that need to be made for medication evaluations, to insure that your PCP is aware of medication changes, to discuss ruling out medical causes for observed behavioral symptoms, and to make him/her aware of your basic treatment plan (not typically the details of your case, just the general symptom presentation and treatment approach). **Also, many insurance companies require that your clinician coordinate care with a client’s PCP as part of treatment and make it a condition of continued authorization for treatment.**

Please check one:

\_\_\_\_\_ I provide consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to consult with/receive information from my PCP/Nurse practitioner or my child’s pediatrician/pediatric office regarding medication, substance abuse, medical, and mental health issues pertaining to this case.

\_\_\_\_\_ I provide consent for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange with my PCP/Nurse practitioner or my child’s pediatrician/pediatric office to exchange verbal information, written information, school records, medical records, and pertinent substance abuse history.

\_\_\_\_\_ I do not authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to exchange information with my PCP/Nurse practitioner or my child’s pediatrician/pediatric office

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Name of PCP/NP/OFFICE Address Phone/Fax #

By signing this form, you acknowledge that you understand that you may refuse to authorize release of confidential information to others if you so choose. You understand that you may revoke this consent at any time in writing. You also understand that this information may be subject to re-disclosure by the party receiving the information and may no longer be protected. By signing this form, you allow your PCP to accept a copy of this form as a valid consent to release information. This consent includes information, which is placed in the record after the date of the consent was signed, unless otherwise noted. Your signature acknowledges that this consent expires when your case is closed or as specified here on/when\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Client Name (Self or Child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_