FAMILY CARE PSYCHIATRY

Release of Information to Physician/Therapist

I hereby——– Do——— Do Not authorize Family Care Psychiatry Services (FCP) to release information contained in my record to my Physician/therapist and for my Physician/therapist to release information to the psychiatry service at FCP. If consent is provided, information will be released as follows:

1. Type of Information to be disclosed: assessment &/or treatment information _
2. This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance upon this release (i.e., we are not responsible for information released prior to revocation.

Physician/Therapist NAME:

Physician/Therapist ADDRESS:

TELEPHONE

FAX:

Client Signature (**or parent/guardian**):

Date:

WITNESS SIGNATURE:

DATE:

*I understand that my consent to release information will include sending of the information below to my PCP, as well as treatment updates, discharge information (e.g. a summary of my treatment) and any other information deemed necessary to coordinate my treatment at Family Care Psychiatry. I understand that this release is reciprocal, meaning that it also permits my PCP to send/communicate information to Family care Psychiatry.