Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow Philmont Guidance Center to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include, but is not limited to, diagnosis, treatment plan, progress notes and medication prescribed.

I, ____ , ___________________________________ , ____/______/_______ ,
(patient name—please print) (insurance identification number) (patient's date of birth)

authorize Philmont Guidance Center, PC to release protected health information related to my evaluation and treatment to:

PCP Name: ____ PCP Phone: __________________________

PCP Address: ___________________________________ ____________________________ _____ _______________
(street) (city) (state) (zip code)

Patient Rights

- You can end this authorization (permission to use or disclose information) at any time by filling out a new authorization form or by contacting the Clinical Director at 215-914-2119.
- 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. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire at the termination of treatment or on the following date: ________________.
I have read and understand the above information and hereby identify my wishes regarding my protected health information:

PLEASE CHECK ONE OF THE FOLLOWING:

1.__________ **YES**, I authorize Philmont Guidance Center to release any applicable mental health/substance abuse information to my primary care physician whose name and address appear above.

OR

2. __________ **NO, I DO NOT** give my authorization to release any information to my primary care physician.

____ ___________________________
(Signature of patient ≥14 years old) (date)

____ ___________________________
(Signature of Parent for child <18 years old) (relationship to patient)

Notice to recipient of information

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.