SOLACE
COUNSELING

Coordination of Care between Health Care Providers and Release of Information

Patient Name:_____Patient DOB:_____

Communication between mental health care providers and your primary care physician (PCP), other mental health (MH) providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your mental health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include 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 our office
•If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
•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 Solace Counseling Associates to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above 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 expires one (1) year from the date of my signature below unless otherwise stated herein.**

Solace Counseling Associates is authorized to release protected health information related to the evaluation and treatment of the patient/member indicated at the top of this form.

Primary Care Physician: _____PCP Phone: _____

PCP Address: _____Fax:_____

Mental Health Provider:_____ MH Provider Phone:_____

MH Provider Address:_____MH Provider Fax:_____

Disclosure may include the following verbal or written information: (check all that apply)

Face sheet___ History & physical___ Laboratory/diagnostic testing results___ School information_____
Medication records____ Mental health/psychological consult_____Psychological eval/testing results___
Psychiatric evaluation___ Psychosocial assessment_____Substance abuse treatment record_____
Summary of treatment records & contact dates_____ Other_____

___ I do not have, or am not receiving services from a PCP or MH Provider at this time and no authorization is required
___ I hereby refuse to give authorization for any release of information to my PCP or MH Provider

_____ _____
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)

Witness: _____

Revised 11/14/17