Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

Last Name_____ First Name _____ Middle Initial _____

Date of Birth _____ Phone Number _____

I hereby authorize the disclosure of protected health information about the individual names above.
I am: ___ the individual named above (complete section 8 below to sign this form)
___ a personal representative because the patient is a minor, incapacitated, or deceased

I hereby authorize SALISBURY PSYCHIATRIC ASSOCIATES
to release/exchange and/or communicate with one another specified information regarding my treatment to

_____

_____

This authorization shall expire 1 year from the date of signature below unless revoked prior to that date.

*You can revoke this authorization at any time by writing to the behavioral health provider named above. If you revoke this authorization it will not apply to information that has already been used or disclosed.
* The disclosed information based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
* You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
* This authorization is completely voluntary and you do not have to agree to authorize any use or disclosure.
* You have the right to a copy of this authorization once you have signed it. Please keep a cop for your records or you may ask for a copy at any time by contacting your behavioral health provider named above.
* I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

Signature _____ Date _____

Signature of Personal Representative (if applicable)

Signature _____ Date _____

Relationship to the Individual: _____