FUELLING & ASSOCIATES, LLC
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(660) 429-6678

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 your Behavioral Health Provider 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 diagnosis, treatment plan, progress, and medication if necessary.

I, _____, _____, _____/_____/_____
(Patient Name - Please Print) Social Security Number Patient Date of Birth - MM/DD/YYYY)

authorize _____, at Fuelling & Associates, LLC to release protected health informatin related to my evaluation and treatment to:

PCP Name: _____ PCP Phone: _____

PCP Address: _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

Information to be completed by Behavioral Health Provider

I saw _____ on _____ for _____
(Patient Name - Please Print) (Date) (Reason/Diagnosis)

Summary: _____

❑ The patient reports taking the following medications prescribed by you: _____
_____
_____

❑ The patient reports the following medication response: _____
_____
_____

❑ The patient is referred to (psychiatrist): _____
❑ The patient refuses referral to a psychiatrist: _____

❑ Other treatment recommendations: _____
_____
_____
_____

If you have any questions or would like to discuss this case in greater detail, please call me at 660-429-6678.

_____ _____ _____
Provider Signature Provider Printed Name Licensure

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting in writing; your mental health therapist; or the secretary at this office
- 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 the Authorization Form may be re-disclosed by the recipient and may no longer be protected by law.
- You do not have to agree to this request to use or disclose your information. Refusal may limit coordination of services and full benefit or effectiveness of treatment.

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 an dthat in any event this consent shall expire twelve (12) months from the date of signature, unless another date is specified. I have read and understand the above information and give my authorization: PATIENT PLEASE INITIAL ONE

_____ To release any applicable mental health / substance abuse information to my primary care physician.
_____ I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____
(Patient Signature) (Date) (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: _____

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREATMENT RECORD

NOTICE OF 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 regulation son the confidentiality of alcohol and drug abuse records (42 CFR Part 2), you are prohibited from making any further disclosre 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 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 an alcohol or drug abuse patient.