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**Consent to Release and Receive Protected Health Information**

***Coordination of Care with Primary Care Physician***

**Communication between your mental health provider and your primary care physician is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your mental health provider to share valuable information with your PCP. No information will be released without your signed authorization.**

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I hereby authorize the disclosure of protected health information and coordination of care for the individual named above. I am the: 🞎** the individual named above 🞎 a personal representative because the patient is a minor, incapacitated, or deceased

**The following behavioral health provider and organization, may disclose and receive protected health information:**

*VISIONS*

*550 Southlake Blvd.*

*North Chesterfield, VA 23236*

*Phone Number: (804) 901-5628*

*Fax: (804) 302-7967*

*www.visionsrva.com*

Name of primary care physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Practice Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address, City, State and Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Information About the Individual Will Be Disclosed?**

Any applicable behavioral health and/or substance abuse information, including diagnosis, treatment plan, prognosis, and medication(s) if necessary.

**The Purpose of the Disclosure**

To release protected health information, evaluation, and/or treatment information to the PCP and from the PCP to ensure quality and coordination of care.

**The Expiration Date or Event**

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

**Important Rights and Other Required Statements You Should Know (Please read and initial each statement)**

\_\_\_\_\_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 information disclosed 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 a right to a copy of this authorization once you have signed it. Please keep a copy for your records, or you may ask for a copy at any time by

contacting your behavioral health provider named above.

**Signature of the Patient** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Personal Representative (if applicable)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date (required) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the individual (required): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***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.*