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AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing *Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2,* and cannot be disclosed without my written consent unless otherwise provided for in state and federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____hereby authorize Angela J. Hartman, Psy.D.

Please check one:

_____ To release information to my Primary Care Physician including diagnosis, brief description of problems, treatment plan and medications.

_____ For my Primary Care Physician to release medical information to Dr. Hartman.

_____ To release medication information only to my Primary Care Physician.

_____ Not to release information to my Primary Care Physician.

_____ _____
(Patient, or patient's guardian, please sign) (Date)

_____ _____
(Please print name signed) (Witness signature)

Primary Care Physician's Name, Address and Phone Number