**NAME OF PRACTICE**

**Authorization to Obtain and/or Disclose Health Information**

**Patient Name**: **DOB**:

*Communication between your Behavioral Health Provider (BHP) and your Primary Care Provider (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your BHP and your PCP to share protected health information (PHI). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, lab tests, and medication, as necessary.*

I, ,

*(Print Parent/Guardian’s name)*

hereby authorize

 *(Print Behavioral Health Provider name and address)*

and

*(Print Primary Care Provider name and address)*

to exchange protected health information related to my child’s medical, mental/behavioral health, and/or substance use diagnosis and treatment for coordination of care purposes.

**Information will be exchanged:** ☐ verbally ☐ in writing/electronically ☐ both formats

**Information to be:** ☐both disclosed and obtained ☐ disclosed only ☐ obtained only

*Please check all that apply:*

☐ Behavioral Health (BH) Admission or Intake Summary ☐ Summary of Most Recent Physical

☐ Summary of BH Treatment or Other Services ☐ Medical History

☐ BH Discharge Summary ☐ Entire Medical Record

☐ Entire Behavioral Health Record

☐ Other BH or Medical Information or Records (specify):

**My Rights**

* *I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment).*
* *I understand that I may revoke this authorization in writing at any time. If I do, it will not affect any actions already taken by the above-named practice based upon this authorization.*
* *I understand that once the practice discloses health information, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.*
* *A copy of this authorization may be utilized with the same effectiveness as the original.*

**Expiration:** This authorization automatically expires *one year from the date of signature* unless otherwise specified in the space provided here: Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Parent/Guardian Signature:** I certify that I authorize the use of my child’s health information as set forth in this document.

*Signature of Parent/Guardian Relationship to Child Date*

*Printed name of Parent/Guardian Signature of Child (recommended if at least 16 years of age)*