**INFORMATION EXCHANGE AUTHORIZATION-Primary Care Physician (PCP)**

It is often helpful to coordinate treatment with your PCP. However, information may not be disclosed without written informed consent for release. You are not required to sign this form and treatment will not be refused if you choose not to sign and permission may be revoked at any time. By signing below you indicate that you give permission for Behavior Health Partners to release the specified information.

**Clients Name: ________________________________________ DOB: ____________________**

I, ________________________________________, parent/guardian of the above-named child,

**Authorize Behavior Health Partners, PLC to: (check one or both below)**

___ release information contained in my records to the physician/organization below

___ request information from the physician/organization listed below

Name:______________________________________________________________

Address:____________________________________________________________

Contact Person:______________________________________________________

This information may be released for the following purpose, use or need:________________________

________________________________________________________________________________

The following information can be disclosed:

☐ ◻ Treatment Summary ☐◻ Psychological Evaluation ◻ Psychological Testing

☐ ◻ Exchange of all written and verbal information pertinent to the coordination of my care and treatment

☐ ◻ Other:_____________________________________________________________

This consent may be revoked at any time. If no expressed revocation is issued, this authorization will expire one year from the date indicated after my signature or upon the following date, event or condition:

_____________________________________________________________________________

**I have also had the opportunity to have this form explained to me and have my questions answered.**

| ____________________________ | ________ | ________________________ | ______ |
|---|---|---|---|
| Client/Parent/Guardian | Date | Witness | Date |