COORDINATION OF CARE BETWEEN HEALTH CARE PROVIDERS AND RELEASE OF INFORMATION

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow Renewed Journey Counseling Services, LLC to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights: You may end this authorization (permission to use or disclose information) any time by contracting the office at (404) 625-5427. If you make a request to end this authorization, understand that information may have already been used or disclosed based on your previous permission. You may be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits. You have a right to a copy of this signed authorization. If you choose not to authorize, it should not affect your benefits or services.

Patient Authorization

_____ I hereby authorize the name(s) or entities written below to release verbally or written information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient.

I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

The name(s) or entities written below are authorized to release PHI related the evaluation and treatment of:

Member: _____ Date of Birth: _____
Member ID: _____ Guardian: _____

PCP Name: _____ PCP Phone #: _____
PCP Address: _____
Psychiatrist:_____ Psychiatrist #:_____
Psychiatrist Address: _____
Other Supports: _____ Phone #: _____
Other Address: _____

Disclosure may include the following verbal or written information (check all that apply):

- ☐ Face Sheet
- ☐ Discharge Summary
- ☐ ER Record Report
- ☐ History & Physical
- ☐ Medication Records
- ☐ Psychiatric Evaluation
- ☐ Behavioral Health/Psych Consult
- ☐ Psychosocial Assessment
- ☐ Summary of Treatment Records and Contact Dates
- ☐ School Information
- ☐ Psychological Evaluation/Testing Results
- ☐ Diagnosis

_____ I hereby REFUSE to give authorization for the release of any information to my outside medical supports. In declining this option, I do understand it could affect my overall medical and mental health. HOWEVER, IF I AM USING MY HEALTH/EAP INSURANCE, I ACCEPT THIS PROVIDER NOTIFYING MY REFERRAL THE DAY AND TIME OF MY INITIAL APPOINTMENT.

_____

Print Client Name **Client Signature** **Date**

_____

If applicable, Authorized Person's Signature **Your Relationship** **Date**

FAX PATIENT RECORDS TO 404.508.8944 ATTN: RECORDS MANAGMENT