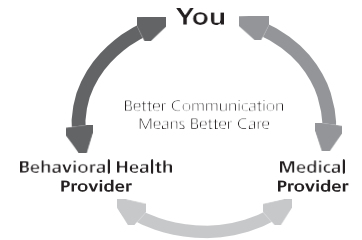


Behavioral Health/Medical Provider Communication Form

(Complete additional forms as needed for each provider.)



Patient Information

Patient name (last, first, m.i.)	Patient birth date (mm/dd/yyyy)	Daytime telephone number
Patient street address	City	State ZIP code

Provider Information Patient does not have a medical provider.

Medical provider name	Medical provider telephone number	Medical provider fax number
Medical provider street address	City	State ZIP code

For Office Use Only:

Behavioral Health provider name	BH provider telephone number	BH provider fax number
Behavioral Health street address	City	State ZIP code
Patient diagnosis:	Initial Intake Date and Treatment Recommendations:	
Patient medications/herbal remedies and dosages:		
Risks/concerns (homicidal/suicidal ideation, etc.):	Comments:	

Patient Rights

- You can end this authorization (permission to use or disclose information) at any time by contacting One-Eighty Counseling, P.A.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT, PLEASE CHECK ONE:

- To release any applicable mental health information to my medical provider.
- To release any applicable substance abuse information to my medical provider.
- I DO NOT give my authorization to release any information to my medical provider

Patient signature	Date
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NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.