Release of Information for Physicians/ Coordination of Care

Counseling Associates for Well-Being
Ph: 706-425-8900 F: 706-425-8600
1 Huntington Rd - Suite 703 Athens, GA 30606

Patient Information

Full Name:	Date of Birth:

Please check one of the following options regarding your counselor's ability to communicate with your Primary Care Physician and/or other Physicians and their Clinical Staff members.

If you check YES, your therapist will communicate with the named physician(s) and/or send a treatment plan and/or therapy progress notes as agreed upon by the patient and therapist.

☐ NO, I **DO NOT** give consent
☐ YES, I **DO** give consent

If you answered 'Yes' above, Please complete the following:
I hereby give my informed consent for my therapist at Counseling Associates for Well-Being to release information in the following ways:

☐ *Verbal* release of information
☐ *Written* release of information

I authorize this information to be provided to the following provider(s):

Primary Care Physician

Name:	Phone:	Fax:
Address:		

Other Provider(s)

Name:	Phone:	Fax:
Address:		

Name:	Phone:	Fax:
Address:		

Patient Authorization: I Understand that this authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization. My refusal to release records will not affect my ability to obtain treatment. If a person or facility receiving the above-stated information is not a healthcare or insurance provider covered by HIPAA, this information could be re-disclosed.

Signature:_____ **Date:**_____