Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

PATIENT CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, ______________________________(patient name) give permission to ______________________________
(Behavioral Health Provider) and my Primary Care Physician ______________________________
(Primary Care Physician) to share information about my diagnosis and/or treatment related to substance
abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the
human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive
better care.

__________________________ 
Patient, Parent or Legal Guardian Signature

__________________________ 
Witness Signature

__________________________
Date

__________________________
Date

Member Refusal to Release Confidential Information

I, ______________________________(patient name) DO NOT give permission to ______________________________
(Behavioral Health Provider) and my Primary Care Physician ______________________________
(Primary Care Physician) to share information about my diagnosis and/or treatment related to substance
abuse, mental health, or medical history, including the results of a blood test for antibodies to the human
immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better
care. I also understand that my refusal to share information does not affect my insurance coverage.

__________________________
Patient, Parent or Legal Guardian Signature

__________________________
Date

__________________________
Witness Signature

__________________________
Date

This consent becomes effective on the date of signing and I can choose to cancel it at any time.