



Life & Work Solutions
healing for your mind & soul

Release to Primary Care Physician for _____ (client's name)

This form will allow your Behavioral Health Provider to share protected health information with your Primary Care Physician. This information will not be released without your signed authorization. You are not required to complete this authorization form.

I _____, hereby authorize staff at **Life & Work Solutions, Inc.** to:

_____ (Initials) Use the following protected health information, and/or

_____ (Initials) Disclose the following protected health information to the Primary Care Physician:

_____ (initials) I refuse to give permission to release/use my information to the PCP.

Name and Agency: _____

Address/City/State/Zip: _____

Telephone: _____ Fax: _____

This protective health information is being used or disclosed for the following purposes:

- Evaluation/Assessment Results
- Progress Updates
- Treatment Recommendations
- Discharge Planning

Other: _____

This authorization shall be in force and effect until _____ at which time this authorization to use/disclose this protected health information expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Life & Work Solutions, Inc.** I understand that a revocation is not effective to the extent that **Life & Work Solutions, Inc.** has relied on the use or disclosure of the protective health information.

I understand that information used or disclosed pursuant to this authorization may be subject to read disclosure by the recipient and may no longer be protected by federal or state law. Refusing to sign this will not condition my treatment, payments, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

 Signature of Patient or Personal Representative

 Date

 Therapist's Signature with Credentials

 Date