

**Appendix E**  
**Release of Information for**  
**Communication with Primary Care Providers**

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**Authorization to Disclose Information**  
**To Primary Care Physician**

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
*(Please Print Patient's Name)* *(Please Print Treating Clinician's Name)*

Please check one:

- \_\_\_\_\_ To release any applicable information to my Primary Care Physician  
\_\_\_\_\_ To release medication information only to my Primary Care Physician  
\_\_\_\_\_ Not to release information to my Primary Care Physician

\_\_\_\_\_  
*(Patient's or Patient's Guardian, please sign)* *(Date)*

\_\_\_\_\_  
*(Please Print the Name Signed Above)* *(Date)*

**Primary Care Physician's Name, Address, and Phone:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Note to Behavioral Health Care Provider:**  
**Please maintain original copy in patient's file.**

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