BALDWIN COUNSELING
Consent to Release Information to
Primary Care Physician(PCP) or Primary Care Manager(PCM)

Insurance companies require the patient to complete the PCP Release form

IF YOU CHECK "YES", A REVIEW OF YOUR DIAGNOSIS AND TREATMENT PLAN <u>WILL BE SENT</u> TO YOUR PRIMARY CARE PHYSICIAN.

_____ ___ ___ ___ -___ ___ -___ ___ ___ ___ ___ ___ -___ ___-___ ___

Name of Patient (last, first, MI) Patient Social Security Number Patient Date of Birth

1. Do you want your therapist to communicate with your Primary Care Physician (PCP) or Primary Care Manager (PCM) to send the treatment plan and progress notes of therapy. ***Please check ONE of the following***

☐ **NO, I DO NOT** give consent to release information to my PCP/ PCM *(Please skip to section 3)*

☐ **YES, I DO** give consent to release information to my PCP/PCM *(Please complete ALL info in section 2 & 3)*

2. If you checked YES, *please complete the following:*

I hereby give my informed consent for_____to
Baldwin Counseling Provider(s)

(check all that apply) ☐ **Talk with Physician** ☐ **Release written documentation** regarding my treatment to

Primary Care Physician or Primary Care Manager_____

Address_____

Phone __ __ __-__ __ __-__ __ __ __ Fax __ __ __-__ __ __-__ __ __ __

3. Patient Authorization: I understand

- 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 Privacy Regulations this information could be re-disclosed.

_____ _____ _____ _____

Signature of Patient *(Or responsible Party if Patient is a Minor)* Date Printed Name (last, first, MI) Relationship to patient

Witnessed by: Baldwin Counseling Representative_____

Date_____ Patient Id_____