DO YOU WANT US TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN?

At BHSI it is our policy and duty to keep your healthcare information private and secure. We do not release information about your healthcare without a written request from you.

Sometimes it is a good idea for a primary care physician and mental health provider to communicate with each other in order to coordinate care. Please indicate your preference by completing one of the two boxes below.

☐ **At this time I do not want BHSI to communicate with my primary care physician. I understand that, if needed, I can authorize this communication later.**

Print your name (or child's, if your child is the patient) _____

Your date of birth (or child's, if child is the patient)_____

Your signature_____Date_____

Witness signature_____Date_____

OR

☐ **I request that BHSI communicate with my primary care physician now because (check any that apply):**

- ☐ **I am being treated by my physician for the same symptoms that I would like BHSI's help with.**
- ☐ **My physician is prescribing medication to improve my mental/emotional functioning.**
- ☐ **My physician is treating a medical problem that also affects my mental/emotional functioning.**
- ☐ **If I need medication, I want my primary care physician to do the prescribing.**
- ☐ **My physician referred me to BHSI.**
- ☐ **I want my physician to know that I am seeking help at BHSI.**
- ☐ **Other reason:_____**

Note: If you give your permission, the following may be exchanged with your medical provider:

Diagnoses	**Physical exam and lab results**	**Medical history**
Progress notes	**Alcohol/drug use**	**Psychological and test results**
Treatment plan	**Treatment recommendations**	

This authorization is for all dates of service, and will automatically expire in one year. I understand that can withdraw this authorization at any time by providing BHSI with a written notice.

Your primary care provider/clinic:_____
Provider address and phone:_____
_____
_____

Print your name (or child's, if your child is the patient)_____

Your date of birth (or child's)_____

Your signature_____Date_____

Witness signature_____Date_____