Stone Arch Psychology and Health Services

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Authorization for Release of Confidential Information to Primary Care Doctor

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Client Name Date of Birth

This form allows SAPHS to release protected personal health information to your primary care doctor, information including: treatment plan, medication and discharge summary. In order to provide information to your primary doctor this form must be completed with your signature.

This form may be revoked at any time by providing a written request to SAPHS, except for information which has already been released. This authorization will expire in one year.

Please designate one of the following:

___ I authorize SAPHS to communicate information with my primary care doctor

___ I do not authorize SAPHS to communicate information with my primary care doctor

___ I do not have a primary care doctor

Doctor Name____

Clinic Cddress """"""""""""""""""""""""""""""""""""""Ekv{ """"""""""""""Uvcvg"""""\ kreqf g

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Phone Number________________________ Fax Number______________________

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Client Signature Date

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Parent Guardian Signature Date