Palos Behavioral Health Professionals
11800 S. 75th Ave., Third Floor
Palos Heights, IL 60463
Phone: 708-671-8440 Fax: 708-671-8446

Consent to Release Information to Primary Care Physician

Communication between your psychiatrist/therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This authorization is valid until _____.

Patient Name: _____ Date of Birth: _____

Please check one:

☐ I agree to release/receive mental health/substance abuse information and records to/from my Primary Care Physician.

The following information is to be used, released, and/or exchanged:

_____ Health/Medical Records
_____ Educational Records
_____ Consultation
_____ Social History
_____ Other (specify): _____
_____ Psychiatric Evaluations
_____ Neuropsychological Evaluation
_____ Treatment Records & Reports
_____ Psychological Assessment & Diagnosis

This information is to be provided for the purpose of:

_____ Coordination of care
_____ Treatment planning
_____ Other (specify): _____

☐ I do NOT give my consent to release any information to my Primary Care Physician and I acknowledge this may impact my coordination of care.

Physician Name: _____

Physician Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

_____ _____
Patient Signature (age 12yrs. & older must sign) Date

_____ _____
Signature of Parent/Guardian or Personal Representative* Date

*If you are signing as a Personal Representative of an individual, please describe your legal authority to act for this individual (Power of Attorney, Healthcare Surrogate, etc.)