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INSURANCE COMPANY AND PRIMARY CARE PHYSICIAN RELEASE FORM

_____ _____
Patient Name Birth Date

_____ _____
Patient's Insurance Insurance ID No.

I authorize my insurance company or other agents paying for my treatment to receive information regarding my mental health or substance abuse care for the purposes of quality assurance monitoring, utilization review and payment of claims. Additionally, my treatment provider and "The Paying Company" may consult with each other and with other health care professionals as necessary to ensure the appropriateness of my care. I also understand my treatment provider will communicate and coordinate my care with my primary care physician as directed in the instructions below. This release shall remain in effect until one year after my last treatment or until the time I revoke this release. I may revoke this release at any time by notifying my treatment provider in writing.

Patient's instructions regarding release of information to primary care physician:

Permission to release mental health and/or substance abuse information to patient's primary care physician to facilitate the coordination of care is: (Patient to initial appropriate choice)

[_____] **Authorized** [_____] **Withheld**

If I am signing for a minor child, I affirm I am the parent or legal guardian of this minor patient.

_____ _____