

## PRIMARY CARE PHYSICIAN CONTACT AUTHORIZATION

### Section 1

Client Name: \_\_\_\_\_ Client ID #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

### Section 2

Please indicate below whether you would like us to contact your primary care physician regarding your treatment at Healing Therapeutic Services, LLC.

I authorize Healing Therapeutic Services, LLC to contact my physician as indicated below for the purposes of continuing care and case coordination. I also authorize my physician to disclose PHI to Healing Therapeutic Services, LLC for the same purposes.

I do not have a primary care physician. I understand that I am encouraged to obtain one.

I do not authorize Healing Therapeutic Services, LLC to contact my physician.

Name of Physician \_\_\_\_\_

Address \_\_\_\_\_  
Street, City, State, Zip Code

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Other Information \_\_\_\_\_

### Section 3

#### Description of Information to be Disclosed

<input type="checkbox"/> Diagnostic Assessment/Evaluation	<input type="checkbox"/> Treatment Plan or Summary
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Billing Records
<input type="checkbox"/> ARMHS Functional Assessment & Treatment Plan	<input type="checkbox"/> Psychological/Psychiatric Assessment
<input type="checkbox"/> Chemical Dependency Evaluation Notes	<input type="checkbox"/> Other Facilities/Lab Reports
<input type="checkbox"/> All Mental Health Information-Dates of Service _____	
<input type="checkbox"/> Other-specify _____	

### Section 4

The Purpose of this Disclosure of information:

Ongoing Care     Consultation     Case Coordination     Other – Specify \_\_\_\_\_

### Section 5

*I understand that information will be disclosed that is protected by Federal Laws and Minnesota Statutes. I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent expires **ONE YEAR** after signature date.*

*I release Healing Therapeutic Services, LLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.*

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Client or \*Legal Guardian/Responsible Party if under 18

\*Relationship to Client \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

#### Healing Therapeutic Services, LLC Office Use Only

Faxed     Mailed     Picked Up    Date: \_\_\_\_\_ Time of Day: \_\_\_\_\_ Initials: \_\_\_\_\_