WHITESELL AND ASSOCIATES, INC

AUTHORIZATION FOR RELEASE OF HEALTHCARE INFORMATION TO PRIMARY CARE PHYSICIAN

Client Name: _____ Date of Birth: _____

I, _____ , do hereby authorize

_____ / Whitesell and Associates, Inc. to release the following information to:
Provider Name

_____

(Name of Primary Care Physician) (Street) (City) (State) (Zipcode)

Phone: _____ Fax: _____

_____ **By initialing here I acknowledge that the following information will be disclosed unless otherwise specified:**

- Suicide Risk and Treatment
- Initial Assessment
- Psychological Testing
- Physical Exam and History
- Medication Orders
- Lab/ Testing Results
- Individual Treatment Plan
- Progress Note(s)

Specific information to be released is as follows: _____

_____

Specific information *not to be disclosed:* _____

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules.

I understand that this information includes treatment for behavioral, mental, and/or physical illness, counseling, or treatment for drug and/or alcohol abuse, infectious/contagious disease including, but not limited to, HIV/AIDS or tests for HIV/AIDS, and developmental disabilities.

Signature:_____ **Date:** _____

Witness:_____ **Date:** _____

If Signed by Legal Representative, Relationship to Patient: _____

Any individual or agency receiving this information is prohibited from making any further disclosure of this information without the specific written consent of the person to whom it pertains (or that of their legal representative), except in those cases consistent with Maryland State or Federal law, statute, or regulation, whereby this information must be produced or otherwise examined.

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