AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) TO PRIMARY CARE PHYSICIAN (PCP)

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

[ ] I do not want any information released to my child's PCP

I understand that if I do not allow my child's medical psychologist (MP) to contact the physician referring and treating my child (viz., the PCP) for the purpose of treatment review, the MP will not prescribe medication to my child.

[ ] I authorize Northshore Counseling & Wellness, LLC to release my child's protected health information to my child's PCP

Dr.: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

A copy of this authorization shall be as valid as the original.

I understand I have the right to:

- Inspect or copy the PHI to be used or disclosed as permitted under federal law (or state law to the extent the latter provides greater access rights)
- Refuse to sign this authorization
- Receive a signed copy of this authorization

_____ _____

Signature of Parent/Guardian and Date Witness and Date