AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL INFORMATION WITH PRIMARY CARE PROVIDER (Including Substance Use Disorder Records)

I, _____ hereby ☐ authorize ☐ decline for Pathways _____
(Name of Consumer – Please Print) *(Program)*
to disclose to, obtain from, and exchange the following information including mental health and substance use disorder (SUD) records, with the following primary care provider:

_____ Phone Number: ( ) _____ – _____
(Name of Primary Care Provider Receiving and/or Exchanging Information)

Address _____

City _____ State _____ Zip _____

Consumer's Date of Birth __ __ / __ __ / __ __ __ __ Consumer's Social Security #: __ __ __ – __ __ – __ __ __ __

TYPE OF INFORMATION TO BE RELEASED AND EXCHANGED

(may include substance use disorder records, if applicable) Check Yes or No **and** Initial

Yes	No	Information	Initial Here
		Any and all information	
		Mental Health Diagnosis	
		Substance Abuse Diagnosis	
		Laboratory Reports	
		Biopsychosocial Summary	
		Physical Health Diagnosis	
		Treatment Plan	

Yes	No	Information	Initial Here
		Psychiatric Medications	
		Psychological Evaluation	
		Discharge Summary	
		Diagnostic Impression	
		Summary of Progress Toward Goals	
		Physical Health Medications	
		Other (specify):	

DISCLOSURES REQUIRING SPECIAL CONSENT:

My signature below specifically authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for HIV/AIDS virus.

PURPOSE OF DISCLOSURE: The purpose of this authorization is to permit the **coordination, integration, and management of my care**, including **treatment, payment, and health care operations**, between my behavioral health providers and my primary care provider.

Time limitation of Release and Revocation: This consent is subject to revocation at any time, providing the information has not already been disclosed. Please see our Notice of Privacy Practices for instructions as to how to revoke this authorization.

- I understand that I may **revoke this authorization at any time** by submitting a written revocation, except to the extent that action has already been taken in reliance on this authorization.

REDISCLOSURE AND USE OF INFORMATION: Information disclosed under this authorization may include records protected by **42 CFR Part 2**. Recipients of this information may **further use and redisclose** it **for treatment, payment, and health care operations** in accordance with **HIPAA** and applicable federal law.

ANTI-DISCRIMINATION NOTICE: Federal law prohibits recipients of this information from **discriminating** against an individual based on the information disclosed, including substance use disorder information, in employment, housing, access to health care, or other services, consistent with applicable law.

Signature of Consumer:	Date:	Signature of Witness:	Date:
Signature of Consumer's/Resident's/Patient's Agent or Representative:	Date:	Signature of Witness:	Date:

This authorization shall remain valid and effective until revoked by the client. No automatic expiration date applies.

At the client's election, this authorization may terminate upon the occurrence of a specified event identified by the client.

Event: _____