Sherry Kleckner Counseling
3677 North 129th Street
Omaha NE 68164
Phone (402)312.1098 Fax(888)944.2541

# Authorization to Disclose

## Protected Health Information to Primary Care Physician

Communication between your therapist and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your therapist to share protected healthy information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. The information disclosed may include diagnosis, treatment plan, progress, and medication if necessary.

I, _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
(Client Name) (Social Security Number) (Date of Birth)

authorize "Sherry Kleckner Counseling", to ☐ release **and/or** ☐ receive protected health information related to my evaluation and treatment to:

**Primary Care Physician Name:** _____ Primary **Care Physician Phone:** _____ Fax**:** _____

**Primary Care Physician Address:** _____ _____ _____ _____
(Street) (City) (State) (Zip Code)

**If you do not have a primary care physician, and would like us to assist you with a referral, please check here**: ☐

## A. Client Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire upon case closing, unless another date is specified:_____ I have read and understand the above information and give my authorization: **CLIENT PLEASE CHECK ONE**

_____ To release any applicable mental health / substance abuse information to my primary care physician.
_____ To release and receive diagnosis and medication information to and from my primary care physician.
_____ I DO NOT give my authorization to release any information to my primary care physician.

_____ _____ _____ _____
(Client Signature) (Date) **OR** (Signature of Client's Authorized Representative) (Date)

## Client Rights

- You can end this authorization (permission to use or disclose information) any time by notifying your therapist
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
  - You have a right to a copy of this signed authorization.
  - You do not have to agree to this request.

**Information to be completed by Therapist:**

**Date client was seen**: _____

**Reason/Diagnosis**: _____

If you have any questions or would like to discuss this case in greater detail, please call me at: _____
(Phone Number)

_____ _____ _____
(Therapist Name) (Therapist Signature) (Licensure)

**NOTICE TO RECIPIENT OF INFORMATION**

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.