bright side COUNSELING

Renee B. Gusman, LPC • Phone 504-813-0951 • Fax 504-486-7595

## Authorization to Disclose Information to Primary Care Physician

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except that action has been taken in reliance on it. If not previously revoked, this consent will terminate upon completion of the specific purpose as

I, _____, Date of Birth _____
(patient's name)

Hereby authorize Renee Gusman, LPC (please check one)

_____ to release any and all applicable information to my Primary Care Physician.

_____ not to release information to my Primary Care Physician.

_____ I do not have a Primary Care Physician.

For the specific purpose of coordinated treatment.

_____ _____
Patient's Signature or Guardian/Responsible Party — Date

Primary Care Physician:

| |
|---|
| Name: |
| Address: |
| Phone: |