Southern Behavioral Healthcare, P.C.

110 Braxton Court

Fayetteville, GA 30214

Phone (770 461- 6422)

Fax (678 610- 7111)

Consent for Release of Information to Coordinate Care with Primary Physicians and Other Providers

Patient Information:	**PCP/Other Provider Information:**
Name:	Name:
DOB:	Phone: Fax:

The undersigned authorizes Southern Behavioral Healthcare, P.C. (Provider) to coordinate care with your Primary Physician/ Other Providers.

Consent to release/obtain medical records and information concerning the patient as communication between both parties is important to make sure all care is complete, comprehensive, and well-coordinated.

This form allows us to share valuable information with your provider as this enhances quality of care, reduces the risk of duplication of tests and medication interactions.

Refusal to provide consent could impair effective coordination of care.

Signature of Patient/Parent/Guardian **Date**

Signature of Witness **Date**

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, can not be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has been taken which was based on my consent.