SPECTRUM PSYCHIATRIC GROUP, P.C.
AUTHORIZATION TO RELEASE INFORMATION TO PCP

In our ongoing effort to coordinate your care, your insurance plan may request that we share certain information with your Primary Care Physician (PCP). We request your permission to release/obtain information to/from your PCP. Please sign this release so that we may communicate with your PCP.

I authorize Spectrum Psychiatric Group, P.C., to release/share information with my PCP.

PCP Name: _____

PCP Address: _____

PCP Phone: _____ PCP Fax: _____

A copy of this authorization is as valid as the original.

I hereby authorize this agency and its staff to☐ obtain or ☐ disclose verbally or in writing the following information (check appropriate box or boxes):

☐Psychiatric diagnosis only	☐Physical exam findings
☐Dates of admission and discharge	☐Psychological testing
☐Intake & assessment summary	☐Drug abuse or alcoholism info
☐Psychiatric evaluation	☐HIV/AIDs information
☐Discharge summary	☐Educational evaluations
☐Progress note(s)	☐Current school adjustment
☐Laboratory data-urinalysis results	☐Any other data custodian deems appropriate
☐Medical evaluation	☐Other, please specify:

For the purpose of (check appropriate box or boxes):

☐Coordination of care	☐Return-to-duty evaluation
☐Treatment & discharge planning	☐Disability determination
☐Treatment & discharge planning	☐Disability determination
☐Insurance authorization/claims processing	☐Vocational rehabilitation
☐Employment-related EAP	☐Educational planning
☐Legal	☐Other, please specify:

I understand that my medical records are protected by the Federal and State Confidentiality Statutes - Connecticut Chapter, 899, PL 93-579 Statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes. I also understand that I may revoke this consent at any time, except to the extent that the action was already taken. The revocation of this consent form requires written notification from the patient or the legal guardian of the patient.

The information to be obtained or disclosed was fully explained to me and was given of my own free will. I understand the medical record to be released may contain information pertaining to psychiatric, drug and/or alcohol diagnoses and treatment, and may also contain confidential HIV/AIDs related information:

Patient signature: _____ Date: _____

Parent/legal guardian signature: _____ Date: _____

Witness signature: _____ Date: _____