Consent to Release Information to Primary Care Physician

Many insurance companies are now requesting that its network behavioral health providers routinely communicate with their patients' primary care physicians in order to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information includes diagnosis, treatment plan, and prognosis. Please fill out the information below and indicate whether or not you wish Doctor Celmer to communicate with your primary care physician.

I, _____, do authorize // do not authorize (Circle one, please)

Doctor Virginia Celmer of 5440 Babcock, #110, San Antonio, Texas, 78240 for the purposes of case consultation and continuity of care to release information related to my evaluation and treatment to my primary care physician,

Doctor_____

Address_____

_____

Phone_____

My Date of Birth_____ My Social Security #_____

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 six months from the date of signature, unless another date is specified.

To The Party Receiving This Information: This information has been disclosed to you from records which are protected by federal and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

I have read and understand the above information:_____

Signature of Patient **Date**

BELOW TO BE COMPLETED BY DOCTOR CELMER

Diagnosis: _____

Treatment Plan: _____

Prognosis: _____

Copies of intake assessment materials are enclosed.

Phone contact: I am available at 210-641-7400 to discuss the care of our patient.

Date these materials are mailed_____ 06/2015