QUALITY BEHAVIORAL HEALTH, INC.
75 Lambert Lind Highway
Warwick, RI 02886
Phone: (401) 681-4274 // Fax: (401) 681-4285

PCP Release Form

Date: _____ Patient: _____

DOB: _____

PCP Name: _____

Practice Name: _____

Address: _____

Phone: _____ Fax: _____

This information is provided to facilitate coordination of treatment/continuity of care. Our mutual patient was seen by me on ____/____/_____.

Should you wish to discuss this case further or need additional information please feel free to call me at your convenience.

_____ _____ _____
PROVIDER SIGNATURE PROVIDER (PRINT) DEGREE/LICENSE

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____do hereby authorize QBH to release and exchange medical/
PATIENT PRINT
psychiatric and psychological information pertaining to me/my child with my primary care physician (PCP). This authorization is for the exchange of information between the PCP and behavioral health clinician, and vice versa. This information will include information concerning diagnosis, treatment plan, and medications. This authorization will expire no later than one year from the date of signature.

Signed: _____ Date: _____
PATIENT SIGN

Notice to Recipient: This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR, Part 2) and/or state law. In accordance with Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the 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. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

PATIENT **REFUSES** or **DOES NOT HAVE A PRIMARY CARE PHYSICIAN**: _____
PATIENT