AFFILIATED PSYCHOLOGICAL & MEDICAL CONSULTANTS, LLC

David S. Bailey, Ed.D., ABPP, FAClinP Stephen P. Farr, Phd., BCIA-EEG
Janice R. Hughes, Ph.D., P.C.
Caleb Loring, Psy. D. Patricia A. McCoy, Ph.D.

AUTHORIZATION TO DISCLOSE INFORMATION TO PRIMARY CARE PHYSICIAN

I understand that my records are protected under the applicable State law governing health care information relating to mental health services and under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Records 42 CRF 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 to the extent that action has been taken in reliance on it. This release automatically expires twelve months from the date sign.

I, _____, hereby authorize Dr. _____
(Please print patient's Name) (Please print name of psychologist)

*****PLEASE CHECK ONE*****

____ Please release any applicable information to the PRIMARY CARE PHYSICIAN listed below

Primary Care Physicians Name, & Phone:
(Please complete this section ONLY if we are to release information)

_____

_____

____ Do not release information to my Primary Care Physician

____ I do not have a Primary Care Physician

_____ _____
(Patient or Patient's Guardian, PLEASE SIGN) (Date)