THE NOWLIN PSYCHIATRIC CLINIC, PC

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PRIMARY CARE PHYSICIAN NOTIFICATION LETTER AND AUTHORIZATION FOR EXCHANGE OF INFORMATION WITH PRIMARY CARE PROVIDERS (PCP)

This information is released for the purposes of management and coordination of my medical and behavioral health care by my health care providers.

I hereby authorize Mary Nowlin, DO to disclose health care information related to the treatment of ___________________________________

Date of Birth__________ to my Primary Care Provider (PCP)

PCP____________________________Phone____________Fax_______

Address____

I understand that my records are protected under federal and state confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. 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. A photocopy of the authorization will be considered as valid as the original.

I DO________or I DO NOT______ want my PCP notified.

Patient signature_________________________Date_______________

Parent/guardian signature__________________Date_______________