3101 American Legion Rd.,Suite 23,
Chesapeake, VA 23321,
Office757-483-2580, Fax 757-483-2939

Consent to Release Information to Primary Care Physician (PCP)

Insurance companies require the patient to complete the PCP Release form

To authorize release of information to physicians, other than the PCP, please complete general release form: 'Authorization to Release Information'

_____ _____
Name of Patient (last, first, MI) Patient's Date of Birth

Please check one of the following:

☐ NO, I DO NOT give consent to release information to my Primary Care Physician (Please skip to section 3)

☐ YES, I DO give consent to release information to the Primary Care Physician (PCP) named below (If you check yes, the therapist will communicate with the named physician and/or send treatment plan and/or progress notes of therapy as agreed upon by the patient and Therapist.) If you checked YES, please complete the following:

I hereby give my informed consent for (Counselor's Name _____ of Fountain of Hope Counseling Center, LLC (s) to (check all that apply)

☐ Talk with Physician ☐ Release written documentation regarding my treatment to

Primary Care
Physcian_____

Address_____

Phone (___) ____-_____ Fax (___) ____-_____

Patient Authorization: I understand • This authorization may be revoked at any time by submitting a written request. Disclosure(s) made prior to receipt of revocation are authorized under the prior authorization. • My refusal to release records will not affect my ability to obtain treatment. • If a person or facility receiving the above stated information is not a healthcare or insurance provider covered by HIPAA Privacy Regulations this information could be re-disclosed.

_____ _____ _____
Signature of Patient Date Printed Name (last, first, MI)
Relationship to patient _____

Witnessed by: staff_____ Date_____