EDEN COUNSELING, LLC

NAME: ______________________________
DATE OF BIRTH: ____________________

BEHAVIORAL HEALTH PROVIDER COMMUNICATION FORM

Patient Consent to Release/Exchange Medical Information (to be completed by patient or parent/guardian)

I, ________________________________, _________________, authorize / do not authorize the exchange of information
(Patient Name) (Date of Birth) (Circle One)

between Eden Counseling, LLC and:

____
Physician Name

____
Physician Address City State Zip

____
Physician Telephone Number / Physician Fax Number

To release/exchange information regarding my mental health/substance abuse treatment and including medical records for coordination of care purposes and as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care, HIV status, substance abuse care, diagnosis, treatment, psychotherapy notes, and/or treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my physician. The information disclosed pursuant to the authorization may be redisclosed by the recipient and no longer protected by the federal privacy regulations.

Requested information: ____
____
____
____
____

____ ____________
Patient/Parent/Guardian Signature Date

____ ____________
Witness Date

Assessment/Admission Date: ____________________________ Diagnosis:_________________________

Treatment Type: ______________________________________ Frequency:_______________________
(individual, family, group, medication) (weekly, bi-weekly, monthly)

____ ____________
Signature with Credentials Date