Request/Authorization to Release Confidential Health Information from Psychologist to Primary Care Physician (PCP).

_____ **I DO** authorize _____ **I DO NOT** authorize the exchange of information **between:**

Life Transformations, LLC
Holly R. Counts, Psy.D.
2670 Woodman Center Court
Kettering, OH 45420
Phone: (937) 439-0505
Fax: (937) 293-0650

Doctor/facility: _____

Address: _____

_____

Phone: _____ Fax: _____

Client name _____ Date of birth _____

Social Security number _____

Behavioral Health Information (completed by therapist)

Initial date of service: _____

Presenting problem: _____

_____

_____

DSM-IV Diagnosis: _____

_____

_____

Treatment goals/clinical focus: _____

_____

_____

_____

Requested information from PCP

_____

_____

_____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:
____ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

X_____ _____ _____

Signature of client/guardian **Printed name** **Date**