

WOULD YOU LIKE ME TO SEND A LETTER TO YOUR PRIMARY CARE PHYSICIAN? IF SO, PLEASE COMPLETE THE FOLLOWING:

AUTHORIZATION TO RELEASE INFORMATION

JOAN L. MOREAU, M.D.
ASSOCIATES IN COUNSELING AND PERSONAL DEVELOPMENT
3 HOSPITAL DRIVE, SUITE 308
LEWISBURG, PA 17837
PHONE: (570)523-7509 FAX: (570) 523-7599

NAME _____ SS# _____

ADDRESS _____ DOB _____

Provider/Requestor: I hereby authorize Joan L. Moreau, M.D. to release to and receive from:

(Name of your family doctor/primary care physician)

(Address)

(Phone Number)

(Fax Number)

For the purposes of continued care and insurance.

For all dates of treatment.

Patient please check one:

- To release any applicable mental health and substance abuse information to my primary care physician
- To release only medication information to my primary care physician
- I do not give my consent to release any information to my primary care physician.

AUTHORIZATION TO RELEASE INFORMATION

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. I also understand that this consent is revocable except to the extent that action has been taken on it already.

I further understand that Joan L. Moreau, M.D. will not condition my treatment on whether I give authorization for the requested disclosure.

Patient Signature (must be over 18)

(Date)

Parent/Guardian Signature (if patient is under 18)

(Date)

Witness Signature

(Date)