Consent for Release of Information to Physician or other Health Care Provider

Patient Name:_____Birth date:_____

Physician/Health Care Provider:_____

Office Address:_____

Phone:_____Fax Number:_____

I hereby authorize Marc Gilmartin, MA and my Health Care Provider to share information pertaining to my medical history, medications, mental health issues, substance abuse issues, treatment plan and other relevant information.

I understand that only the minimal amount of information necessary for treatment will be shared and that the purpose is to help both health care providers coordinate care and provide higher standards of treatment. The authorization may be revoked at any time.

Specific Information to be disclosed:_____
_____
_____
_____

Specific purpose for disclosure:_____
_____

☐ This is a 90 day authorization to request or disclose healthcare information

OR

☐ This authorization allows mutual exchange of information between the entities listed above in order to provide and/or coordinate care until 30 days after discharge from this episode of care, unless revoked by client.

☐ I agree to share information with my physician/health care provider

☐ I decline to share information with my physician/health care provider

Signature of Patient or Legal Guardian Date

_____ _____

Witnessed by Date

_____ _____