Columbia Counseling Center
COLUMBIA BEHAVIORAL MEDICINE, P.A.

PRIMARY CARE PHYSICIAN(PCP) AUTHORIZATION FORM
FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print)**:** _____

Date of Birth: _____ **Social Security Number:** _____

By signing this authorization form, I understand that I hereby request and authorize _____, Columbia Counseling Center, to release or receive verbally or in writing my protected health information, as described in more detail in the paragraph below, to the following primary care physician:

NAME OF PRIMARY CARE PHYSICIAN: _____

Street address: _____City: _____ State: _____ Zip code: _____

Telephone number: _____ Fax number: _____

PURPOSE OF THE USE AND DISCLOSURE: Communication necessary for treatment and coordination of care with PCP

SPECIFIC DESCRIPTION OF INFORMATION: Information pertaining to treatment, patient's current status, symptoms, diagnosis, and medications.

I understand that I may revoke this authorization at any time by providing a written notice to Columbia Counseling Center, 900 St. Andrews Road, Columbia SC 29210. I also understand that such a revocation will have no effect on any information already used or disclosed by Columbia Counseling Center prior to the receipt of such notice. Unless earlier revoked, this authorization will expire twelve (12) months after date of termination or as otherwise specified: _____.

If neither Federal nor South Carolina privacy law applies to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or S.C. privacy law.

This authorization is voluntary and I may refuse to sign this authorization form. I understand that I am not required to sign this authorization form in order for the patient to receive treatment from Columbia Counseling Center. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the primary care physician named in this form.

_____ _____
Signature of Patient or Personal Representative Date

_____
Printed Name of Patient or Personal Representative

_____
Relationship to patient giving representative authority to act for patient *(if applicable)*