Notification of Treatment and Authorization to Release Healthcare Information
Authorization for Primary Care Physician and Behavioral Health Providers

My consent is valid for one year from my signatures date on this form. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I revoke my consent earlier, this consent will expire automatically as follows:

Patient First Name:	**Patient Last Name:**	**Patient DOB:**

I, (Patient/Guardian Name) _____ give permission to (LAMOUR Behavioral Health Provider) and my Primary Care Physician (Primary Care Physician & Other Behavioral Health Providers) to share information about my diagnosis and / or treatment related to substance abuse, mental health, or medical history. I understand the purpose of sharing information is to help me receive better care.

Definition: Mental Health Services, Neuropsychological Testing, Psychiatry, Substance Abuse Treatment, Drug and Alcohol Testing, Psych Testing, Psycho harm, Developmental Testing, Inpatient Treatment, Preventive Medicine, Internal Medicine.

☐ Yes ☐ No I authorize the release of my treatment at LAMOUR Clinic by my Primary Care Physician, and my Primary Care Physician Treatment to LAMOUR Clinic.

☐ Yes ☐ No I authorize the release of any records regarding HIV treatment.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Print Individual Name:		
Print Name of Primary Care Physician Contact:		
Clinic/Hospital/ HealthCare Facility:		
Address:	**Town:**	**Area code:**
Phone:	**Fax:**	

Print Name of Behavioral Primary Contact:		
Clinic/Hospital/ HealthCare Facility:		
Address:	**Town:**	**Area code:**
Phone:	**Fax:**	

****Must be signed by adult in custody if patient is under 18****

Printed Patients Name:	
Patients Signature: **Date Signed:**	

Printed Parent/Guardian/Adult in Custody:	
Patients Signature: **Date Signed:**	**Relationship to patient:**