BAY AREA BEHAVIORAL SERVICES

135 North Moon Avenue
Brandon, Florida 33510

AUTHORIZATION FOR RELEASE OF INFORMATION BETWEEN BAY AREA BEHAVIORAL SERVICES & PCP

Communication between your Primary Care Physician and Bay Area Behavioral Services may be beneficial to your treatment process. Prior authorization is required from you, as client or as a client guardian, for such communication to occur.

I, (Responsible Party) _____ hereby authorize the release of any information requested from my Primary Care Physician (Dr. Name) _____ by Bay Area Behavioral Services in order to provide clinical/ therapeutic services to (Client Name) _____ . This information would include any and all documentation contained within the medical file of the above named client.

I, (Responsible Party) _____ hereby authorize the release of information by Bay Area Behavioral Services to my Primary Care Physician, (Dr. Name) _____ regarding clinical/therapeutic services provided to (Client Name) _____. Such information is to include:

- **Psychiatric Records**
- **Treatment Plan**
- **Clinical Treatment Updates**

I understand that I may revoke this authorization at any time by providing written notice. This authorization automatically expires upon discharge from treatment.

_____ _____
Signature of Responsible Party **Date**

_____ _____
Printed Name of Responsible Party **Date**

_____ _____
Witness Signature **Date**

_____ _____
Witness Printed Name **Date**