Prevail Counseling Group, PLLC   6893 139th LN, NW   Ramsey, MN 55303
Phone 763-427-2590   Fax 763-427-2579   www.prevailcounselinggroup.com

PRIMARY CARE PHYSICIAN CONTACT AUTHORIZATION

Section 1

Client Name: ______________________________ Client ID #: ____________________

Date of Birth: ____________________

Section 2

Please indicate below whether you would like us to contact your primary care physician regarding your treatment at Prevail Counseling Group, PLLC.

[ ] I authorize Prevail Counseling Group, PLLC to contact my physician as indicated below for the purposes of continuing care and case coordination. I also authorize my physician to disclose PHI to Healing Therapeutic Services, LLC for the same purposes.

[ ] I do not have a primary care physician. I understand that I am encouraged to obtain one.

[ ] I do not authorize Prevail Counseling Group, PLLC to contact my physician.

Name of Physician____

Address ____
Street, City, State, Zip Code

Phone ______________________________ Fax ______________________________

Other Information____

Section 3

Description of Information to be Disclosed

_____ Diagnostic Assessment/Evaluation
_____ Progress Notes
_____ ARMHS Functional Assessment & Treatment Plan
_____ Chemical Dependency Evaluation Notes
_____ Treatment Plan or Summary
_____ Billing Records
_____ Psychological/Psychiatric Assessment
_____ Other Facilities/Lab Reports
_____ All Mental Health Information-Dates of Service ______________________________
_____ Other-specify ____

Section 4

The Purpose of this Disclosure of information:

[ ] Ongoing Care   [ ] Consultation   [ ] Case Coordination   [ ] Other – Specify ____________________

Section 5

I understand that information will be disclosed that is protected by Federal Laws and Minnesota Statutes. I understand that I have a right to revoke this authorization at any time, in writing, but that the revocation will not have any effect on the information released prior to notification of cancellation. If I refuse to sign this consent, treatment will not be withheld. A photocopy of this authorization will be treated in the same manner as the original. I understand that this consent ***expires ONE YEAR*** *after signature date.*

I release Prevail Counseling Group, PLLC from any and all liability resulting from disclosure. I do not authorize re-release of this information to anyone. I have read this consent prior to signing and I understand its contents.

Signed ____ Date ____________________
Signature of Client or *Legal Guardian/Responsible Party if under 18

*Relationship to Client ____

Witness ____ Date ____________________

Prevail Counseling Group, PLLC Office Use Only

[ ] Faxed   [ ] Mailed   [ ] Picked Up   Date: ____________________ Time of Day: ____________ Initials: _____