Richard Gottlieb, M.D., Psy.D.
Psychiatry and Psychoanalysis

Coordination of Care between Health Care Providers and Release of Information

Communication between Dr. Gottlieb and your primary care physician (PCP) and/or other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow Dr. Gottlieb to share protected health information (PHI) with your PCP or other medical or behavioral health provider. This information will not be released without your signed authorization. The PHI may include diagnosis, treatment plan, progress notes, and medications taken, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting this office in writing.
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you decline to consent to this request, neither your treatment services nor your fees will be affected.

Patient Authorization

I hereby authorize Dr. Gottlieb to release verbally and/or in writing information regarding any medical, psychiatric, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to me. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

I the undersigned, hereby allow Dr. Gottlieb and his/her office assistants to contact the following individual or agency:

_____ _____ _____

Healthcare Provider Name | Address | Telephone

I understand the purpose is to exchange important information for diagnostic and/or therapeutic reasons. Information authorized to be exchanged includes only the following:

[ ] Psychological test results
[ ] Psychiatric hospital records
[ ] Out-Patient treatment report
[ ] Psychotherapy notes
[ ] Vocational test results
[ ] Medical hospital records
[ ] Laboratory test results
[ ] Other:_____

Date consent given: ____/____/____ Expires: ____/____/____

Patient name: _____

Date of birth: _____ Last 4 digits of Social Security #: _____

_____ _____

Patient or Legal Guardian | Witness

[ ] I hereby refuse to give authorization for any release of information

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Consent revoked this _____day of _____, 20_____

_____ _____

Patient | Witness

I understand that my records are protected under Federal (42 CFR Part 2) and/or state confidentiality regulations. Upon revocation of authorization, further release of information shall cease immediately. File copy is equivalent to the original. This release of information expires in (30) days following completion or termination of treatment, whichever is later. If information that is released relates to substance abuse treatment, these records confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit anyone who receives these records from any further disclosure of it without specific written consent to the person to whom it pertains. A general authorization for the release of medical information is not sufficient to release substance abuse records. The Federal Rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State laws may also protect the confidentiality of patient's records.