Authorization to Exchange Protected Health Information with Primary Care Physician
Pathways Psychological Services, P.A.

7575 Golden Valley Road, Suite 230
Golden Valley, MN 55427
Phone: 763-525-8590 Fax: 763-525-8592

19230 Evans Street N.W., Suite 202A
Elk River, MN 55330
Phone: 763-241-8157 Fax: 763-241-7670

Communication between Pathways and your Primary Care Physician (PCP) helps ensure you receive the best possible care. Your completion of this form allows Pathways to share your Protected Health Information with your attending physician. Your protected information will only be released with your signed authorization.

Client Name (print): _____ Date of Birth: _____

Please check one then sign the form below. If you check #3, please provide your physician's information.

1) ____ I do <u>not</u> wish to authorize release of my protected health care information to a primary care physician.
2) ____ I do not currently have a primary care physician.
3) ____ I authorize _____, of Pathways Psychological Services, to exchange my protected health information (including dates of visits, progress notes, tests, treatment plan, medication, etc.), with:

PCP Name: _____ Phone: _____
PCP Address: _____ Fax: _____
_____
_____

****** Patient Rights ******

You are not required to sign this form. You have a right to a copy of this signed authorization. Information disclosed as a result of a signed authorization could be disclosed by the recipient to another party and no longer protected by law. Pathways Psychological Services only releases records created by our personnel. This authorization expires one year from the date of client's signature. You can terminate this authorization at any time by submitting a signed written request to your therapist at Pathways. I hereby release and agree to indemnify Pathways Psychological Services, its contractors and employees from all liability, damages, and costs arising from the acts or omissions of other persons or organizations. I have read and understand the above information:

Client or Authorized Representative Signature: _____ Date: _____

If signed by Authorized Representative, state relationship to client: _____

To be completed by Pathways Personnel

I have seen this patient from _____ to _____ for a total of _____ sessions.

Present diagnosis: _____.

Current course of treatment: _____
_____
_____.

Please contact me at the Golden Valley or Elk River address at the top of this form if you'd like to discuss this further.

Provider Name: _____ Date: _____
Provider Signature: _____ License: _____