

**MEDICAL INFORMATION AND RELEASE**

**Primary Care Physician and Address**

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Physician's Name

FAX #

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Physician's Address

Phone

Dear Dr. \_\_\_\_\_

Your patient, \_\_\_\_\_, is currently in treatment with me. I hope that the following information will be helpful in coordinating this patient's care.

Authorization to Release Confidential Information  
to my Primary Care Physician

**A.** This form authorizes Earl Friesen, M.A., to release information from the patient's/my records maintained while the patient/I was treated by this provider.

**B.** The information to be disclosed includes presenting problems, diagnosis, medications, expected outcomes and other pertinent information.

Presenting Problems:

Diagnosis:

Medications:

Expected Outcomes:

**C.** I understand that, by law, I need not consent to the release of this information. This information is not required for my/the patient's treatment. However, I willingly choose to release it for the purpose(s) specified above. I understand that I may revoke this release at any time within 90 days, except to the extent that action has been taken in reliance on my consent. Please check one of the following consent:

To release any applicable mental health/substance abuse information to my primary care physician.

To release only medication information to my primary care physician.

I do not give my consent to releasing any information to my primary care physician.

**D.** Also, please note the following points:

1. This information has been disclosed to you from records whose confidentiality is protected by state and federal law. Federal regulations (43 C.F.R. Part 2, Sections 2.31(a) and 2.33) and state regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

**Earl Friesen, M.A., LMFT - Life Skills Plus, Inc.**

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2. This is strictly confidential material and is for the information of only persons who are professionally capable of understanding, appreciating and acting upon it according to their specific and advanced professional training in the mental health field. Please restrict the availability of these records to those persons in your employ who have the training and experience to interpret and understand the information contained in them. These ethical and legal responsibilities are yours. No responsibility can be accepted by the provider or author of these records if this material is made available to any other person or persons who lack such training, or who would not treat it in a professionally responsible manner, or who otherwise should not have access to it, *including the patient*.

3. Redisclosure or retransfer of these records is expressly prohibited, and such redisclosure may subject you to civil and criminal liability.

4. Federal and state rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

**E.** I affirm that everything in this form that was not clear to me has been explained to my satisfaction.

**F.** A photocopy of this release is to be considered as valid as the original.

**G.** Signatures:

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Signature of client	Printed name	Date
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Signature of parent/guardian/representative	Printed name	Relationship Date
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I witness that the person understood the nature of this request/authorization and freely gave his or her consent.

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Signature of witness	Printed name	Date
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Copy for client or parent/guardian  Copy for provider  Copy for Primary Care Physician