ELLEN V. GARBUNY,LSW
340 North Main Street
Suite 101
Butler, PA 16001
724-283-1593

Authorization to Disclose Protected Health Information to Primary Care Physician

I understand that my records are protected under the applicable federal and state laws governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve (12) months from the date signed.

I, ________________________ hereby authorize Ellen V. Garbuny, LSW
(Print patient's name)

Please check one:

_____ To release any applicable information to my Primary Care Physician
_____ To release only medication information only to my Primary Care Physician
_____ Not to release information to my Primary Care Physician.

_____________________________________ _________
(Patient's or Patient's Guardian signature) (Date)

_____________________________________ _________
(please print name signed above) (Date)

Primary Care Physician's Name, Address and Phone:

Original copy of this release is Behavioral Health Provider's Patient File.