Nystrom & Associates, LTD.

Psychiatry & Medication Management
Primary Care Provider Release of Information

Address: _____
City / State: _____ Zip: _____
Phone: _____ Fax: _____

Patient Full Name: _____ **Date of Birth:** _____

Nystrom Provider: _____

☐ **Send information about my initial evaluation and treatment plan to my Primary Care Provider. Coordinate with my Primary Care Provider as necessary for care.**

(Unless otherwise specified, the option above includes all Substance Use and/or mental health related information)

☐ **Do not coordinate care with my Primary Care Provider**

☐ **I do not have a Primary Care Provider.**

I authorize Nystrom & Associates, LTD. to RELEASE to and RECEIVE from:

Primary Care Provider/Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand the following: See 45 CFR §164.508(c)(2)(i-iii) a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. A photocopy of this authorization will be treated in the same manner as the original. This authorization will remain valid until care is terminated with NAL or this authorization is revoked by the patient. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use disorder Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient Signature: _____ **DATE**: _____

Legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

NOTE: If signed by someone other than the patient, we need written proof of authority.

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.