THIS IS NOT A REQUEST FOR RECORDS

NORTHLIGHT PROVIDER/PRIMARY CARE PHYSICIAN COMMUNICATON FORM

Client Consent to Exchange Information (to be completed by client): I,____.
(Please print)

DOB:__________________authorize/do not authorize __________________________________, my Northlight provider and
(Circle one) **(Provider's name)**

____, ____
(Primary Care Provider name) **(PCP Address and Phone Number)**

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect until 6 months after termination of treatment. I understand that I may revoke this authorization at any time by written notice to the above Northlight provider. I also understand that it is my responsibility to notify my Northlight provider if I choose to change my Primary Care Provider.

____ ________________________

I Authorize Communication Between My PCP and
My Northlight Provider (Client's Signature) Date

____ ________________________

I Do Not Authorize Communication Between My PCP and
My Northlight Provider (Client's Signature) Date

____ ________________________

Signature of Parent, Guardian (if Client is a Minor) or
Additional Participant Date

____ ________________________

Witness Date

Provider/Location Information (to be completed by Northlight provider) – Please Print/Circle Location
(Please note: Phoenix address is also mailing/billing address)

5050 N 8th Place, #8 Phoenix, AZ 85014	4121 E Valley Auto Dr.,#122 Mesa, AZ 85206	1405 N Dobson Rd., #1 Chandler, AZ 85224

DSM IV Diagnosis code and name:____
Medication(s) Prescribed:____
____
Comments:____
____

____

Print Northlight Provider Name **Signature/Credentials** **Date**

A copy of this form must be sent to the Primary Care Provider, retaining the original in the client's chart. If the form is sent by fax, attach confirmation that fax was sent. Please Check Method: Fax____ Mail ____

_________________ ____________

Date Sent Sent by (Provider please initial)