Linder Psychiatric Group, Inc.
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[] 970 Reserve Drive Suite 205, Roseville, CA 95678 Ph: (916) 780-1070 Fax (916)780-1199
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Hours of operation 7:30am-5:00pm Clinicians Pagers/Cell Phone Available 24 hrs
Website: www.echildpsychiatry.com

AUTHORIZATION FOR THE EXCHANGE OF MEDICAL RECORD INFORMATION: MEDICAL/PSYCHIATRIC/DRUG/ALCOHOL INFORMATION

Name of behavioral Health Care Specialist:_____

I authorize my Behavioral Health Specialist to share information about my treatment with my Primary care Physician and /or other treating Behavioral Health Care Specialist as follows:

Name:_____

Address:_____

Phone:_____

Fax:_____

I understand that the information shared between the above parties may include:

- A Behavioral Health Specialist may include, but is not limited to, a psychologist, psychiatrist, licensed clinical social worker, or marriage and family counselor.
- The information shared may include:
  - Mental Health/Psychiatric treatment information hand history, including of alcohol and/or substance abuse, medical records and lab reports
  - Treatment dates, diagnosis, medications prescribed and admissions to hospitals, out patient centers or other facilities.
  - Evaluation and treatment plan.
- The purpose of this sharing is to ensure that my Behavioral Health Care and my general medical care are coordinated, which will contribute to the best overall treatment for me.

I understand this information will not be used for any purpose other than for which it is intended.

This authorization will be in effect unless specifically terminated in writing.

( ) Yes ( ) No I authorize my Behavioral Health Care Specialist to share information with my Primary Care physician as outlined above:

Signature of Patient: _____

Name of Patient: _____

Signature of Legal Representative (if required): _____