Behavioral Health Forms

Authorization for Release of Information

I, ____, authorize/do not authorize
(Member's Name) (Circle one)

____
(Primary Care Provider's Name)

to release an initial summary and progress notes to my behavioral health provider for continuity of care purposes and to release information to above-named behavioral health provider and AMERIGROUP or its designee as may be necessary for the administration and provision of my healthcare coverage. The information released may include information on mental healthcare, substance abuse treatment or other medical or clinical information.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I understand that I may revoke this authorization at anytime by written notice to the above-named treatment provider and AMERIGROUP.

____ ___________________
Signature (if minor, signature of parent or guardian) (Date)

____ ___________________
(Witness) (Date)