Wellsprings
PSYCHOLOGICAL RESOURCES®

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Authorization to Release Information to Primary Care Physicians

Wellsprings is required by many insurance companies to communicate with your primary care physician. Please provide the doctor's information with whom you wish us to share or receive information.

Client's Name: _____ **Date of Birth**: ____/_____/_____

Parent/Legal Guardian (for minors): _____ **Relationship**: _____

I hereby authorize Wellsprings Psychological Resources to exchange information with:

Primary Care Physician/Agency Name: _____

Mailing Address: _____

Phone Number: (_____) _____-_____ **Fax Number**: (_____) _____-_____

☐ **I do not have a primary care physician.**

I authorize the release of information, for the purpose of coordination of care and consultation, with the above-mentioned physician or agency.

I understand that:

- This Authorization is voluntary and that I have the right to refuse to give permission for communications.
- This release is in effect until a change of information or until I provide Wellsprings notice otherwise.

I have had the opportunity to review and consider the contents of this authorization. By signing this form, I am confirming that the information above is correct.

_____ _____/____/_____
Signature of client (or legal guardian, for minors) Date

_____
Printed name of client (or legal guardian, for minors)