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 with or receive information.

Client's Name: ____ **Date of Birth**: ____/_____/________
MM DD YYYY

Parent/Legal Guardian: ____________________________________ **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.
- ☐ Please do not release information to my PCP.

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 sign it.
- 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 personal representative) Date

____
Printed name of client (or personal representative and his/her relationship to patient)

____
OFFICE USE ONLY: Wellsprings Staff Initial