VISTA EAP/Intentions Yoga

Cynthia N. Herzog, LCSW, CAP, ICADC, E-500 RYT, C-IAYT

Authorization to Disclose Protected Health Information to Primary Care Physician

I, ____, ________________________________, _____________
(Client Name – Please Print) (Client ID/SS Number) (Client DOB—MM/DD/YYYY)

authorize **Cynthia N. Herzog**, to release protected health information related to my evaluation and treatment to:

Physician Name: ____ **PCP Phone**: _________________________

Physician Address: ________________________________ __________________ ________ _______________
(Street) (City) (State) (Zip Code)

I saw _________________________________ on _______________ for ___________________________________
(Client—Please Print) (Date) (Reason/Diagnosis)

Summary: ____

____

____

____.

Other treatment recommendations: ____.

If you have any questions or would like to discuss this case in greater detail please call me at: **(407) 324-9440 or (407) 461-7657**

_________________________ | *Cynthia N. Herzog, LCSW, CAP, ICADC, 500 E-RYT, Clinical Director* | License #: SW2024
(Provider Signature)

Client's Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire in six (6) months from the date of signature, unless another date is specified, I have read and understand the above information.
CLIENT PLEASE CHECK **ONE**.

_____ To release any applicable mental health / substance abuse information to my primary care physician

_____ To release only medication information to my primary care physician.

_____ I **DO NOT** give my authorization to release any information to my primary care physician.

_______________________________ _____________ ___________________________________ _____________
(Client Signature) (Date) (Signature of Client's Authorized Rep.) (Date)

If signed by Authorized Representative, describe relationship to patient: ____.