Alysia Kirk, LCSW
Clinical Social Worker
39 White Avenue Crafton, PA 15205
Telephone: 412-921-3549

Consent to Obtain/Release Confidential Information From/To Primary Care Physician(s)

This information is needed to assist in evaluation and treatment planning. I understand that this gives my consent for release or exchange of previous treatment information and that this information is to be held strictly confidential and cannot be released again without my written (verbal if necessary) notice. I also authorize that a facsimile of this release is as valid as the original. I further understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ____ hereby authorize Alysia Kirk, LCSW____
(Patient's Name in Print)

Please check only one:

_____________ ***Not*** to release to or exchange with my Primary Care Physician(s) *any* information.

_____________ To release to or exchange with my Primary Care Physician(s) *any applicable* information.

_____________ To release to or exchange with my Primary Care Physician(s) *only medication* information.

Patient's Signature: ____ Date: ___________________

Please print name signed above: ____

* *

Name of Primary Care Physician(s):____

Address of Primary Care Physician(s):____

Phone Number of Primary Care Physician(s):____

Current Medications (Name & Dose): ____

Former Medications (Name & Dose): ____

Current Medical Conditions for which you are being treated: ____

____

Allergies (Indicate none if none): ____

Adverse Medication Reactions (Indicate none if none): ____

Non-Smoker: ☐ Smoker: ☐ If smoker, how much per day:______________________________

No Alcohol Used: ☐ Alcohol Used: ☐ If used, how much per week:______________________________