# Watershed Wellness, LLC

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## AUTHORIZATION TO DISCLOSE MEDICAL RECORD INFORMATION TO PRIMARY CARE PHYSICIAN AND MENTAL HEALTH THERAPIST

Patient's Name: _____
Patient's Date of Birth: _____

I, _____ authorize Brian Callahan, LPCMH, ICADC to disclose
(Signature of Patient/If minor, Legal Guardian)

the following information in order to coordinate treatment; mental health, including alcohol and substance abuse to:

Primary Care Physician Name:_____

Primary Care Physician Address: _____

_____

Therapist Name: _____

Therapist Address: _____

_____

*I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.*

_____ _____
(Signature of Patient/If minor, Legal Guardian) (Date)

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I DO **NOT** WISH TO AUTHORIZE RELEASE OF INFORMATION

_____ _____
(Signature of Patient/If minor, Legal Guardian) (Date)

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