METROPOLITAN
PSYCHOLOGICAL ASSOCIATES, P.C.

Behavioral Health Provider/Primary Care Physician Communication Form

I, _____ authorize/do not authorize
(**Please Print**) **(Circle one)**

Jeremy Novak Ph.D., LP, my behavioral health provider, and _____
(Primary Care Physician/PCP Name)

_____
(PCP Address and Phone Number)

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

_____ _____
I Authorize Communication between my PCP Date
and Behavioral Health Care Provider (Members Signature)

_____ _____
I Do Not Authorize Communication between my PCP Date
and Behavioral Health Care Provider (Member's Signature)

_____ _____
Signature of parent or guardian Date

_____ _____
Signature of witness Date

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