Better Health
Better Choices, Better Doctors. . . Better Health.

## Authorization for Release of Medical Information

**Primary Care Physician request release of Enrollee's medical record, when medically necessary.**

**To Better Health Care, Inc,**

**I,** _____ authorize/ do not authorize
***(Member Name)*** ***(Circle one)***

_____
***(Primary Care Provider)***

To release an initial summary and progress notes on my health condition to my behavioral healthcare, substance abuse treatment, or other medical or clinical information. I also know that this authorization allows setting up a continuing plan of care and information to be released to my behavioral healthcare provider and to Better Health or its designee as may be needed to administer my healthcare coverage.

I understand that this consent shall remain in effect for one year or throughout this course of treatment, whichever is longer. I also understand that I may cancel this authorization at any time by written notice to the above named treatment provider and Better Health, Inc.

**SIGNATURE**: **DATE:**

***(If minor, signature of parents or guardian)***

**WITNESS**: **DATE:**