WBS

Wayne Behavioral Service, LLC

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

---

MEMBER CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) give permission to Wayne Behavioral Service, LLC and my

Primary Care Physician (PCP) _____ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, NOT including the results of blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

I can choose to revoke this consent at any time.

_____ _____
Member/Guardian/Authorized Representative - Printed Date

_____
Member/Guardian/Authorized Representative - Signed

_____ _____
Witness – Print & Sign Date

MEMBER REFUSAL TO RELEASE CONFIDENTIAL INFORMATION

I, _____ (Member Name) **DO NOT** give permission to Wayne Behavioral Service, LLC

and my Primary Care Physician (PCP) _____ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, including the results of blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative - Printed Date

_____
Member/Guardian/Authorized Representative - Signed

_____ _____
Witness – Print & Sign Date

I can choose to revoke this consent at any time.