Consent to Release Health Information

You may be working with a number of medical and alternative health care providers to reach your mental, emotional, and physical health goals. We believe our patients receive the best results and care when there is transparency, communication and collaboration amongst the providers who are invested in your well-being.

By completing this form, you are give permission for Oceans & Rivers to be in communication with your primary care provider, your behavioral health care providers, or your alternative health care providers to share health information about you for the purpose of planning and coordinating your care.

Provider Name/ Speciality	Phone	Address

I ____ (print name) consent to my health information being shared with the providers listed above.

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(Signature) (Date)