Patient Care Communication Form

Physician's Name ______________________________ Telephone Number ____________

Address ____

Dear Doctor ______________________________

Your patient, ____________________ was recently referred by ____________________.

We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: ________________ Date of Next Appointment: ____________

Diagnoses and/or presenting problems: ______________________________

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Treatment Recommendations: ______________________________

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____

Medications: ____

Please call if further information would be helpful

Clinician's Printed Name ______________________________

Address ______________________________

Address ______________________________

Telephone Number ____________________

Sincerely,

____

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2 A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, ______________________________ hereby authorize ______________________________

Print Patient's Name *Print Treating Clinician's Name*

Please Check One:

____ To release any applicable mental health information to my primary care physician (PCP) named above.

____ To release any applicable substance abuse information to my PCP named above.

____ To release only medical information to my PCP named above

____ Not to release any information to my PCP named above

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment

______________________ ______________________ ______________________

Print Name of Patient or Guardian ID Number Date of Birth

______________________ ______________________

Signature of Patient or Guardian Date