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Therapist/Physician Patient Care Communication Form (rev. 2/13)

Patient Name: _____ Date of Birth: _____

Therapist Name: _____

Primary Physician: _____ Address: _____

Phone: _____ Fax: _____

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulationhs governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in-state or federal regulations. The release of any information concerning AIDS, HIV infection, and AIDS-related Complex and the performance of any tests, counseling, and the results and treatment thereof are also authorized. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance to it.

I, _____, hereby authorize information on my (or my child's) care to be shared **as indicated below:**

- o For my therapist to release any applicable information to my (or my child's) primary care physician
- o For my (or my child's) primary physician to release any applicable information to my therapist
- o My therapist may **NOT** release information to my (or my child's) primary care physician

_____ Date _____

Signature of patient (or parent, if a minor)

THE INFORMATION BELOW WILL BE COMPLETED BY THE THERAPIST:

Information sent to Primary Care physician includes:

____ "I recently completed a mental health evaluation on..."
____ "I recently completed a psychological evaluation on..."
____ "I have been working with the above named patient since _____"

"I am currently seeing the patient(s) for the purpose of...:"

___ Individual psychotherapy ___Family psychotherapy ____Parenting strategies Other _____

Diagnosis:

(1) Code: _____ Description: _____

(2) Code: _____ Description: _____

Therapist signature: _____ *Date* _____