COORDINATION OF CARE WITH PRIMARY CARE PHYSICIANS AND HEALTHCARE PROVIDERS

PATIENT SECTION

Patient Name

Patient Email

Patient Phone

Patient DOB

Name of Patient's Primary Care Physician (PCP)

PCP's Phone No.

PCP's Fax

PCP's Address

☐ I AUTHORIZE the disclosure of confidential mental health information between my Mental Health Provider and my Primary Care Physician/Healthcare Provider. I give permission to disclose diagnoses and treatment information about my child or me for the purposes of continuity of care. I understand an expressly authorize the release of information related to any Substance Abuse or HIV status. This authorization is valid unless revoked by me in writing at any time.

Patient/Legal Representative Signature

Date

☐ I REFUSE to authorize the release/exchange of any behavioral health and medical information between my Mental and Behavioral Health Provider and my Primary Care Physician/Healthcare Provider to promote the continuity of my behavioral health care and my general medical care.

Patient/Legal Representative Signature

Date

BEHAVIORAL HEALTH PRACTITIONER SECTION

Dear

I saw your patient for an initial evaluation on

Current diagnoses are

(For Psychiatrists) I have prescribed the following medication and dosages

Outpatient care is appropriate at this time and the initial treatment will consist of the following

☐ Medication Management ☐ Individual Psychotherapy ☐ Family/Conjoint Therapy ☐ CD IOP

Inpatient care/partial hospitalization is necessary and patient has been referred to

If you need additional information, please contact me at SCPC CUSTODY CONTRACT (859) 935-9104

Provider Name

Date

Provider Signature

License No