HEALTH CARE COORDINATION FORM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name _____ Date of Birth ____ ____ ____

Member ID Number or Social Security Number: _____

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment. This includes information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician.

Physician Name _____

Address: _____

Phone Number: _____ FAX Number _____

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature of Patient or Legal Guardian _____ Date

Dear Dr._____

In order to coordinate care, I wish to inform you that patient _____

was referred to me for treatment on___/___/_____. The DSM-IV diagnosis code is___

Outpatient care is being delivered and the treatment plan consists of the following modalities:

☐ Individual Psychotherapy	☐ Couples Therapy
☐ Family Psychotherapy	☐ Medication Management
☐ Group Psychotherapy	☐ Other ( )

Medications are being managed by

Dr. Medications and Dosages:

1) _____
2) _____

If you need additional information, contact me at (714) 557-3742

Sincerely,

Clinicians Name Renee Alpert PhD Signature

Renee Alpert Licensed Clinical Psychologist
Mailing address 3610 E WOODBINE RD ORANGE, CA 92867
(714) 557-3742 FAX: 714-283-3032 Email
alpert@psychologyfirm.com