Psychological Health ★ Roanoke PC

Date: ____________________

Patient name: ________________________________ DOB: ____________________

Release for Coordination with Primary Care Physician:

To coordinate care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. I hereby authorize the use of disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release which can be done at any time.

☐ **I do not have a Primary Care Physician.**

Check one: ☐ I do ☐ I do not give permission to the Primary Care Physician named below to exchange information about my current treatment with my therapist.

Name of Primary Care Physician: ____

Name of Practice or Location ____

SIGNATURE IS REQUIRED

Patient (Guardian) Signature ______________________________ Date: ____________________

Witness Signature: ______________________________ Date: ____________________

Below this line to be completed by Psychological Health Roanoke Clinician

To: ____

Name of Practice or Location ________________________________

Dear Dr. ____

To coordinate care, I want to inform you that your patient, named above, was seen by me on ___/___/___ for treatment of ____.

Current recommendations for the type and setting of treatment include:

___ Individual psychotherapy ___ Evaluation ___ Inpatient unit

___ Family psychotherapy ___ Intensive outpatient program

___ Group psychotherapy ___ Partial hospitalization program

Comments: ____

If you need further information, please contact me at 540-772-5140 or fax to 540-772-5157.

Clinician Signature: ______________________________ Date: ____________________