Psychological Health ★ Roanoke PC

Date: _____

Patient name: _____ DOB: _____

Release for Coordination with Psychiatrist:

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 psychiatrist.**

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

Name of Psychiatrist: _____

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: _____