Continuity and Coordination of Care
Authorization and Release of Information

Village Presbyterian Church
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Licensed Psychologist

Coordination of care between and among your behavioral health care providers and primary care physician can be important. If you are willing, I request that you authorize and consent to the exchange of health information between your health care providers**.** *Please indicate your wishes below:*

My Name Printed____Date of birth______________________

___**I want** Dr. Dave Ehman to notify my primary care physician that I have initiated counseling. *I am willing to provide contact information for my physician below*. This consent will last for one year from the date signed, and I understand that I may revoke my consent at any time.

___**I do <u>not want</u>** Dr. Dave Ehman to notify my primary care physician that I have begun counseling. *Skip the rest of this form and sign below.*

___**I do <u>not have</u>** a primary care physician. *Skip the rest of this form and sign below.*

Physician Name____

Address____ **Telephone**____________________________

____ **Fax**__________________________________

Clinical information to be released to physician

Dear Dr.______________________:

The above named client was initially seen in counseling on: ____

The following provisional diagnosis was assigned: ____

Coordination of care issues/other significant information impacting medical or behavioral health care:

____

____

____________________________________	_____________	____
Printed name of Therapist	Date	Signature

___________________________________	________________	______________________________________	______________
Client signature	**Date**	**Witness**	**Date**

If requested, date mailed or faxed to provider_________________