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_____