Counseling Connections for Change, Inc.
Mental Health Matters!

Behavioral Health / Medical Provider Coordination of Care

Please complete this form so that Counseling Connections for Change, Inc. may communicate with your Primary Care Physician or Psychiatrist. If there is no physician/psychiatrist or you do not want to disclose information, please indicate with an "X" at the bottom of the page and sign name.

Client's name:	Birth date:
Client's home address:	Daytime phone #:

Primary Care Physician or Psychiatrist Information

___ Client **does not** have a medical health provider.

Primary Care Physician's Name:	Physician's Address:
Primary Care Physician's Phone #:	Primary Care Physician's Fax #:
Current Treatment and Medications:	

_____Client **does not** have a Psychiatrist.

Psychiatrist's Name:	Psychiatrist's Address:
Psychiatrist's Phone #:	Psychiatrist's Fax #:
Current Treatment and Medications:	

Client Authorization:

____ I understand that I am NOT required to sign this authorization as a condition of receiving services from Counseling Connections for Change, Inc. The reason for disclosure is to facilitate continuity and coordination of treatment and may include the diagnosis of a mental health disorder. I understand I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier. Expiration Date:

I give my authorization:

____to release any applicable mental health information to my Primary Care Physician/Psychiatrist listed above.
____ to release any applicable medical information FROM my Primary Care Physician/Psychiatrist to Counseling Connections for Change, Inc.
___ I DO NOT give authorization to release any information to my Primary Care Physician/Psychiatrist.

Client's Signature or Parent/Guardian's Signature

X ______________________________________ Date: ____________________

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This release is to inform you that I am seeing a patient of yours for counseling services and wanted to let you know that the client has signed this release to coordinate care on his/her behalf.

Date Faxed to PCP/Medical Provider: ______________By: _______
Risks/Concerns: _____________________________________Notes: _______________________________________

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Rev. 3/18