Psychological Health Roanoke PC

Patient Name_____

Date _____ DOB _____

Release for Coordination With Primary Care Physician:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or 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. **Name of Primary Care Physician**

_____

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

(Check One) I do ☐ I do NOT ☐ give permission to the practitioner named above to exchange information about my current treatment with my primary care physician.

SIGNATURE IS REQUIRED

Patient (Guardian) Signature_____ Date _____

Signature of Witness _____ Date _____

Below this line is to be completed by
Psychological Health Roanoke Clinician

To:_____
_____
_____

Dear Dr. _____:
In an effort 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**
- ☐ **Family Psychotherapy**
- ☐ **Group Psychotherapy**
- ☐ **Evaluation**
- ☐ **Intensive Outpatient Program**
- ☐ **Partial Hospitalization Program**
- ☐ **Inpatient Unit**

Comments:_____
_____

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

Sincerely,
Clinician: _____