



**Psychological
Health
Roanoke_{PC}**

Patient Name _____
DOB _____

Date _____

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
- () Inpatient Unit
- () Evaluation
- () Intensive Outpatient Program
- () Partial Hospitalization Program

Comments: _____

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

Sincerely,
Clinician: _____