Psychological Health Roanoke PC

Date _____ Patient Name_____
DOB _____

Release for Coordination With Psychiatrist:

For the purpose of coordinating care, my behavioral healthcare practitioner may wish to release pertinent information about my current treatment to my psychiatrist. 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 Psychiatrist

_____

☐ **I do not have a psychiatrist.**

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

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 **( ) Evaluation**
( ) Family Psychotherapy **( ) Intensive Outpatient Program**
( ) Group Psychotherapy **( ) Partial Hospitalization Program**
( ) Inpatient Unit

Comments:_____
_____I
f you need any further information, please contact me at 540-772-5140 or fax at 540-772-5157.

Sincerely,

Clinician: _____