Harbor Psychologist, Inc.

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Behavioral Health / PCP Coordination of Care Form

Coordination of Care Form PCP Office: Please place copy of form in patients chart. This form is intended to coordinate care with primary physicians and medical specialists. This is not intended to replace the agency's existing release of information form.

Primary Care Physician, Provider or clinic: ____

Phone number ______________________ Fax ___________________________

Street Address ____

City _______________________________ State__________ Zip ___________

Patient Information

Name: ____________________________ DOB: ________________ Date of Evaluation: _____________________

Reason for referral: Risks, Concerns, (homicidal/suicidal ideation, etc.)

____

____

Diagnoses: ____________________ Medications Currently prescribed: (including herbal)

____

Treatment Plan or recommendations:

____

Medical follow-up recommended:

____

____

Treating Behavioral Health Provider: ____________________________________ Date Sent: ___________________

Patient Rights:
You can end this authorization at any time. If you make a request to end this authorization, it will not include information that has already been used for disclosed based on your previous consent. You cannot be required to sign this form as a condition of treatment or payment. Information disclosed as a result of this Authorization Form may be re-disclosed by the recipient and is no longer protected by law. You do not have to agree to this request to use or disclose your information.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date is specified. I have read and understand the above and give my authorization:

☐ To release any applicable mental health/substance abuse information to my medical provider
☐ To release only medication information to my medical provider
☐ I DO NOT give my authorization to release any information to my medical provider.

Patient Signature:____ Date: ______________