HOPE FOR A BETTER TOMORROW

PRIMARY PHYSICIAN & PSYCHIATRIST-PATIENT CARE COMMUNICATION FORM

Clinicians at Hope for a Better Tomorrow strive to deliver the best possible care for their clients. In order to uphold this high standard, we ask for permission to notify your primary care physician and/or psychiatrist. By signing this form, it gives your Hope for a Better Tomorrow therapist permission to contact your primary care physician and/or psychiatrist to introduce themselves as your behavioral health care practitioner and work directly with them when necessary (for example: strategies for better medication management, coordination of care and treatment recommendations).

If you have further questions regarding this form, please consult with your therapist.

Physician or Psychiatrist Name:_____

Address:_____

Phone:_____ **Fax:**_____

____ Yes, I want this information released to my Primary Care Physician or Psychiatrist.
____ No, I do not want this information released to my Primary Care Physician or Psychiatrist.
____ I do not have a Primary Care Physician or Psychiatrist at this time.

Authorization to Disclose Information

To the patient: Disclosure of the above information is for coordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected under federal law. Releasing this information to your physician is strictly voluntary and does require your written consent for this form to be sent, it does not allow for any other information to be disclosed nor does it allow for any form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided to you. To the party receiving the information: This information has been disclosed to you from records whose confidentially is protected by federal law. Federal regulations prohibit you from making further disclosure of this information.

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year.

Print Patient Name: _____

Signed:_____ _____ _____
(Client 12 years of age and older) Date Witness

Signed:_____ _____ _____
(Parent or Guardian Signature, 12 years and younger) Date Witness

OFFICE USE ONLY
Letter and Form Sent: _____
Date & Initials