21395 John Milless Drive I Suite 400 I Rogers, MN 55374
Phone: 763.424.1888 I Fax: 763.424.7288
www.northwindscounseling.com

Client Care Communication Form

Care Provider ___________________________
Address ___________________________

Phone________________________________
Fax: ________________________________

Northwinds Counseling Provider ________________
21395 John Milless Drive #400
Rogers, MN 55374
Tel: 763-424-1888
Fax: 763-424-7288

It is our desire to inform primary care providers when their patients are receiving services at Northwinds Counseling Services P.A. to facilitate the best possible coordination of care.

This is for your information. There is no need to reply unless you deem it helpful or appropriate.

Regarding:
Patient Name: ____ D.O.B. ________________________

Patient/Legal Guardian: ____
Date of initial assessment:___________________________Follow-up appointment _________________

Therapist notes regarding presenting problems, provisional diagnosis and treatment plan:

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Please call if we can be of further help and support.

AUTHORUIZATION TO DISCLOSE THE ABOVE INFORMATION

To the party receiving this information:

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART2

Patient Signature _______________________________________ Date______________________

Parent /Guardian ______________________________________ Date______________________

Witness Signature ______________________________________ Date ______________________