



21308 John Milless Drive | Suite 202 | Rogers, MN 55374  
Phone: 763.424.1888 | Fax: 763.424.7288  
www.northwindscounseling.com

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## Client Care Communication Form

Care Provider _____	Northwinds Counseling Provider _____
Address _____	21308 John Milless Drive #202
	Rogers, MN 55374
Phone _____	Tel: 763-424-1888
Fax: _____	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.

**AUTHORIZATION 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 _____