**PSYCHOTHERAPY &PASTORAL COUNSELING ASSOCIATES**

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# Primary Care Physician Notification/ Coordination Form

**TO:** ***Primary Care Physician (PCP)***

Name: ______________________________________________

Address: ______________________________________________

______________________________________________

Phone: ____________________

**RE:** ***Client***

Name: ______________________________________________

DOB: __________________ SS#: __________________

**Authorization to Disclose Information to Primary Care Physician**

I understand that my clinical records are protected under applicable state and federal laws governing confidentiality and information relating to mental health care, relating to drug and alcohol services and relating to communicable disease. I also understand that I may revoke my consent to information disclosure at any time. The authorization I give below will automatically expire twelve months from the date of my signature.

I, ________________________________________, hereby authorize ____________________________________________

(Client printed name) (Therapist printed name)

Please check one of the following:

_____ To release/discuss any pertinent medical/mental health information with my primary care physician

_____ To release/discuss only medical information with my primary care physician

_____ Not to release/discuss any information with my primary care physician

Client (parent) signature: ________________________________________ Date: ______________________

Therapist signature: ____________________________________________ Date: ______________________

________________________________ (FOR OFFICE USE ONLY BELOW THIS LINE) ____________________________

**FROM:** ***Behavioral Health Provider***

Name: ______________________________________________

Address: ______________________________________________

______________________________________________

Phone: ______________________

**Level of Behavioral Care:** __________________________________________

**Date of First Contact:** __________________________________________

**TREATMENT PLAN** (include goals, interventions and target dates for completion):

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**MEDICATIONS:**

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

**ELOS:** ____________________________________________________________________

Therapist signature: _____________________________ Date: ___________________