

**Matthew A. Berger, MD, PC**  
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**PRIMARY CARE PHYSICIAN  
FOLLOW-UP**

Name \_\_\_\_\_ Date \_\_\_\_\_ Patient Account # \_\_\_\_\_  
(Please Print) (Office Use Only)

It is important to recognize your Primary Care Physician as the coordinator of your health services. This office would like to inform your Primary Care Physician that you are participating in services from this office. No specific information regarding your care will be released without your written consent. Sometimes you need to see a number of different providers to get all the services you require. This includes behavioral health providers and physical health providers. All of your providers and your health insurance plans should work together to provide you with the best possible care, but your providers and health plans can share only limited information without your permission.

By signing this form, you are telling us that it is OK for your primary care provider and your behavioral health care provider to share certain health information about you for the purpose of planning and coordinating your health care. Sharing this information allows your providers to better manage and coordinate your health care.

Examples of how this information may help include: making sure the medications that you are taking are safe to take together; coordinating the health care services you are receiving; and making sure the health care you are receiving is helping to keep you healthy and well.

Your permission will last for one year from the date that you sign this form as long as your insurance coverage remains the same. You can cancel your permission at any time. This will not take back information that was already shared, but it will stop your health information from being shared any further when sharing would require your permission. If you want to cancel your permission, you must do so by contacting this office and completing a new form.

Please consider giving us permission to share information about your mental health and physical health.

\_\_\_\_\_ I **agree** Matthew A. Berger, MD, PC or his designee may contact my Primary Care Physician regarding my participation in counseling services.

\_\_\_\_\_ I **decline** at this time to have my Primary Care Physician contacted regarding my participation in counseling services. I will notify you if I decide in the future to have you contact my Primary Care Physician.

\_\_\_\_\_ Primary Care Physician Name \_\_\_\_\_ Primary Care Physician Phone \_\_\_\_\_

Patient Signature\* \_\_\_\_\_ Date \_\_\_\_\_  
Legal Guardian Name\*\* \_\_\_\_\_  
Legal Guardian Signature\*\* \_\_\_\_\_ Date \_\_\_\_\_

\*If patient is **14 or older**, patient must sign all paperwork and add legal guardians to their HIPAA.

\*\*If patient is **13 or under**, a legal guardian must sign all paperwork.

**If you have any questions, please ask our staff.**