CANO COUNSELING
www.canocounseling.com

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Health Care Coordination Form

PHYSICIAN'S NAME

ADDRESS CITY STATE ZIP CODE

PHONE NUMBER FAX NUMBER

TO BE COMPLETED BY CLINICIAN

I do not need information from you at this time. This document is to inform you that your patient:

NAME OF PATIENT DOB

has started treatment with me. This information is for coordination of care purposes. Outpatient care is being delivered and the treatment plan consists of the following modalities:

☐ Individual counseling ☐ Couples Counseling ☐ Family Counseling

DIAGNOSIS

If you need any information, please contact me directly at 508-882-7127. When and /or if I need any information I shall contact you.

AUTHORIZATION AND CONSENT TO RELEASE AND RECEIVE CONFIDENTAL INFORMATION TO PRIMARY CARE PHYSICIAN AND OR/OTHER HEALTH CARE PRACTITIONERS.

PATIENT NAME DOB

By initialing all information items, I approve, I authorize release and receipt of the following medical information between the Health Care Practitioner(s) named above and Gladys Cano, LICSW

☐ Mental Health Diagnosis ☐ Substance Abuse Information

☐ Other Mental Health Treatment Information ☐ Medication Management Information

I understand that the release and receipt of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed. The patient has the right to revoke this authorization in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I hereby release Gladys Cano, LICSW from all legal responsibility or liability that might arise from the act I have authorized above. I understand that information use or protected by HIPPA Privacy. I understand that the information authorized by this consent will be provided to the authorized representative (s) only. Additional information may be provided to those recipients only with a signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

PATIENT'S SIGNATURE DATE