COORDINATION OF HEALTH CARE FORM

Dear Dr. ________________________________,

Your patient, ___________________________, is receiving behavioral health services. This information may be helpful for you in managing the patient's medical care.

The current diagnosis is _____________________________.

Medications are being managed by Dr. Tejaskumar B. Patel.

Current medications are: ____.

Treatment goals include: ____

____.

If you need additional information or have questions, contact me at (520) 639-8576.
Sincerely,

_____________________________ _____________________

Provider's Signature Date

****CONSENT TO RELEASE INFORMATION****

Patient refused to authorize communication. Do not send form; place in patient's file.

Consent to release/exchange information signed below:

I hereby authorize release and/or exchange of information with my Primary Care Physician to allow for coordination of my care and treatment. I understand this authorization may be revoked by me at any time, except to the extent action has been taken.

_______________________________________ ____________________

Patient/Parent/Legal Guardian's Signature Date

This information has been disclosed to you from records whose confidentiality is protected by Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under such law, you are prohibited from making any further disclosure of these records without the specific written consent of the person to whom they pertain or as otherwise specifically required or permitted by law.