Horizon
Psychological Services, P.C.
19425 Liverpool Pkwy Ste B2, Cornelius, NC 28031 (704) 960-2632

Health Care Coordination Form

In order to coordinate care, I wish to inform you that your patient, _____ (Date of Birth _____), was seen by me on ____/_____/_____.

Outpatient services are being delivered using the following modality:

____ Individual Psychotherapy for treatment of _____ .

____Psychological evaluation for assessment of _____.

Other_____

If you need any additional information, please feel free to contact me at (704) 960-2632.

Respectfully,

_____

Consent for Release of Confidential Information to Primary Care Physician (PCP)

I hereby authorize the release of medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician.

_____ _____ _____

Physician name and Practice **Phone number** **Fax number**

____ Please send to my PCP. I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. I further understand that I have the right to receive a copy of this authorization upon my request.

_____ I do not authorize the release of information to my PCP.

_____ I have no current PCP

_____ _____

Signature of Patient or Legal Guardian **Date**

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