



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
<input type="checkbox"/> 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.		
<input type="checkbox"/> I do not authorize the release of information to my PCP.		
<input type="checkbox"/> I have no current PCP		
Signature of Patient or Legal Guardian	Date	

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