PRIMARY CARE PHYSICIAN NOTIFICATION

Primary Care Physician Name: _____

Primary Care Physician Address: _____

Primary Care Physician Telephone: _____

This notification is to inform you that I am seeing the following patient. I am available by telephone to consult with you regarding this case.

Patient Name: _____ Date of 1st Session: _____

Social Security No.: _____ Today's date: _____

Date of birth: _____

Type of Service: Current Psychiatric Medications:

☐ Psychiatric Evaluation _____

☐ Medication Management _____

☐ Therapy _____

☐ Other _____

Authorization for Release of Confidential Information:

I, _____, hereby freely, voluntarily and without coercion, authorize
(Name)
_____ to release information and/or a copy of my clinical records to
(Provider Name)
_____. The reason for this disclosure is: coordination of treatment
(Primary Care Physician)
services.

Signature: _____ Date: _____
(Patient, Parent, or Legal Guardian)

_____ _____
(Relationship to Patient) (Witness)

Treating Physician: _____
Address: _____
_____
Telephone: _____
Fax: _____