Mazzitti and Sullivan Counseling Services, Inc.
3207 North Front Street, Harrisburg, PA 17110 Phone: 717-901-5652 Fax: 717-540-6874

PATIENT CARE COMMUNICATION FORM

Doctor: ______________________________ Telephone: ____________________

Address: ____

Dear Doctor ______________________:

Your patient, ______________________________ DOB: ______________ was recently referred to our agency for a/an ______________________ evaluation. We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation: ____

Diagnosis or Presenting Problems: ____

Treatment Recommendations: ____

Please do not hesitate to call if further information would be helpful.

Sincerely,

____

Clinician's Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, ______________________________ hereby authorize ______________________________

Patient's Name (Print) Treating Clinician's Name (Print)

Please Check One:

________ To release applicable mental health information to my primary care physician (PCP) named above.

________ To release substance abuse information to my primary care physician (PCP) named above. This information will be limited to client involvement, diagnosis, prognosis, type of treatment, progress and relapse frequency.

________ To release only medical information to/from my primary care physician (PCP) named above.

________ Not to release any information to my primary care physician (PCP) name above, for the reason noted below:

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

______________________ ______________________ ______________

Client Witness Date

<u>I have been offered a copy of this form which I have accepted refused.</u>