American Behavioral Clinics

Patient Care Communication Form
Release of Protected Health Information to Physician

Patient Name: _____ DOB: _____

Physician's Name (Primary/Other physician): _____

Physician's Address: _____

City _____ State _____ Zip _____ Phone # _____

(To Be Completed by office staff)

Dear Dr.: _____

Date of Initial Assessment:_____

Diagnosis and/or presenting problem: _____

_____

_____

Medication(s): _____

_____

Sincerely, _____ Date: _____

Authorization to Disclose Information

To the Patient: Disclosure of the above information is for the co-ordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected by federal law. Releasing this information to your physician is strictly voluntary and does require that your written consent for this form be sent to your physician. It does not allow for any other information to be disclosed nor does it allow for any other form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided for you.
To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making further disclosures of this information.

Patient to Complete the Following:

_____ I want this information to be given to my physician.

_____ I DO NOT want this information to be given to my physician.

_____ I do not have a primary care physician at this time. I will inform my doctor if/and when I do obtain one.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Form Originated from the following location:

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