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Release and Coordination of Care Information

Patient Name: _____ DOB: _____
(please print)

Dear _____: The patient listed above has signed this release authorizing me to contact you.
(PCP/Provider)

[X] This is ***NOT*** a request for records. This release is for co-ordination of care purposes.

[ ] This ***IS*** a release authorizing an exchange of information for the purpose of co-ordination of care.
Please send records for the following dates _____ to the person and address listed above.

Patient presented with the following symptoms or concerns:

[ ] ADHD	[ ] Domestic Violence	[ ] Psychosis	[ ] Substance Use/Abuse
[ ] Anxiety	[ ] Grief	[ ] PTSD	[ ] Suicidality
[ ] Bipolar	[ ] Marital/Rel Concerns	[ ] School/Job	[ ] Addictions _____
[ ] Depression	[ ] Parenting/Discipline	[ ] Separation/Divorce	[ ] _____

Initial Appointment: _____ Last Seen: _____ Termination Date: _____

Treatment Plan: Individual Therapy _____ Couples/Family Therapy ____ Other: _____

Additional Information: _____

PCP/Provider: _____ Phone: _____ Fax: _____

Address: _____

Initial: _____ I specifically authorize the release of information concerning Alcohol and/or Drug Treatment.

Initial: _____ I specifically authorize the release of information concerning HIV status or testing.

Initial: _____Prohibition on Redisclosure:
To persons receiving released information: This information has been disclosed to you from records protected by federal regulation, which prevents you from making any further disclosures without specific written consent of the person to whom it pertains. I understand that I may revoke this authorization at any time except after the information has already been released. Furthermore, I herewith release and hold harmless Lisa Alber, LICSW from any liability for the release of these records.

This authorization expires upon termination of therapy, or as indicated below.

I understand that this authorization is voluntary and that I have the right to refuse to disclose this information.
I understand that my healthcare and payment of my healthcare will not be affected by this form.

_____ _____ _____
Patient (or Guardian) Signature Today's Date Expiration of Release