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COORDINATION OF CARE WITH PRIMARY CARE

PHYSICIANS AND HEALTHCARE PROFESSIONALS

Patient Name____

Date of Birth____

Patient Address____

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Name of Patient's PCP_______________________________________

PCP's Phone # PCP's Fax_____________________________________

I authorize the disclosure of confidential mental health information between Heather Luevano and my Primary Healthcare Provider. I give permission for disclosure of diagnosis and treatment information about my child or me for the purpose of continuity of care. I understand and expressly authorize the release of information related to any substance abuse or HIV status.

This authorization is valid for one year and may be revoked by me in writing at any time.

Patient/ Legal Guardian______________________________________

Signature_____________________________Date________________

OR

I refuse to authorize the release/ exchange of any behavioral health and medical information between Heather Luevano and my (or my child's) Primary Healthcare Provider to promote the continuity of my (or my child's) behavioral health and general medical care.

Patient/ Legal Guardian______________________________________

Signature_____________________________Date________________