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Sylvia K. Neal, LCSW, PLLC

# Consent To Release/Exchange Information

☐ **Consent to communicate with signed below.**
☐ **Patient Refused to authorize communication.**

**I hereby authorize release and/or exchange of information with physician:___________________ to allow for coordination of my care and treatment. I understand that this authorization may be revoked by me at any time, except to the extent that action has been taken.**

_________________________________ _____________________________
(Patient/Parent/Guardian) (Date)

_________________________________ _____________________________
(Witness) (Date)

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THIS SECTION BELOW IS FOR CLIICIAN USE ONLY

# Coordination of Health Care

**Dear Dr.________________________,**

**Your patient, _______________________ is receiving behavioral health services. This information may be helpful to you in managing the patient's care.**

**The current diagnosis is ______________________________________**

**Medication is being managed by Dr. ___________________________**

**Current Mediations are_______________________________________**

**Treatment goals include______________________________________________________________**

**_________________________________________________________________________________**

This information has been disclosed to you from records whose confidentiality is protected by confidentiality provisions of most states' law and applicable federal law. Under such law, you are prohibited from making any further disclosure of these records without specific written consent of the person to whom they pertain or as otherwise specifically required or permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal regulations under 42 CPC Part 2 restrict any use of the confidential information to criminally investigate or prosecute any alcohol or drug abuse patients.