SUMMACARE

Informed Consent to Coordinate Care

TO: _____
_____
_____

Your patient was recently evaluated at our office. We hope the following information will be helpful in coordinating the patient's care.

Patient Name:_____

Date of Initial Consultation: _____Date of next Appointment:_____

Diagnosis/Presenting Problem(s):_____

Interventions/Goals/Medications:_____

_____

_____

Follow-Up Care:_____

Please call if further information is necessary.

Patient Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under Federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This authorization will automatically expire if the member's health plan policy is terminated by the member, health plan, or employer.

I understand this information will be used to coordinate care among my providers.

I, _____hereby authorize_____to
Print Patient's Name Print Treating Provider's name

(Please check one)
____ Release only the information listed above to my provider
____ Release **TO** and/or obtain **FROM** any applicable information regarding my treatment
____ Do not release any information to my provider
____ I do not have any other providers

Additional information to be released _____

_____

_____ _____
Patient or Guardian Signature Date Witness Date

I hereby revoke the above release:

_____ _____
Patient or Guardian Signature Date Witness Date