

**HEALTHCARE COORDINATION FORM**  
**\*\*\*THIS FORM IS NOT A REQUEST FOR RECORDS\*\*\***

**Please complete the information above the dotted line and return with your packet to the Children's Program. Do not send to other providers. Many managed care health insurance companies will require this form to be on file and mailed to a primary care provider after your visit.**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PHYSICIAN NAME _____	PHONE NUMBER _____
ADDRESS _____	
_____	

I  authorize  do not authorize: the release of the form letter below or a written report/letter if available to my primary care provider.

In addition to the information provided on this form, I specifically authorize the release, either verbally or written, of the following information:

\_\_\_\_\_

\_\_\_\_\_

This Information is needed for: Coordination of Care  Treatment Planning  Other \_\_\_\_\_

I may revoke this release at any time, and I understand that such a revocation will not affect information released prior to that revocation. Unless subsequently revoked, this consent will expire in one hundred eighty (180) days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. I approve the release of this information. I understand what this agreement means. I am signing of my own will and have not been pressured to do so.

Signature of Patient or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_

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Dear Dr. \_\_\_\_\_,

I wish to inform you that this patient was seen by me starting \_\_\_\_\_.

The plan is \_\_\_\_\_.

Outpatient care is being delivered and the treatment plan consists of the following modalities:

\_\_\_\_\_ Therapy, \_\_\_\_\_ Medication Management, \_\_\_\_\_ Other.

\_\_\_\_\_

If medication (s) is being prescribed, medications and dosages: 1) \_\_\_\_\_ 2) \_\_\_\_\_

If you need additional information, please contact me at: \_\_\_\_\_

Sincerely,

\_\_\_\_\_ Signature \_\_\_\_\_

\*This information has been disclosed to you from records protected by Federal and States rules of confidentiality which prohibit further re-disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.