



PATIENT CARE COMMUNICATION FORM

Improving Care Coordination between psychiatrists and primary care physicians

Treating psychiatrist's contact information:

Dear Dr. _____, Address _____

Your Patient, _____, was recently seen in our office. We hope that the following information will be helpful in this patient's care.

Date of Visit: _____ Initial _____ Follow-up _____

Diagnosis and/or presenting problems:

Treatment recommendations:

Psychiatric Medications:

Laboratory needing to be followed:

If there is any medical information that may relate to the patient's mental health (such as chronic medical problems, allergies to medication, current medications and dosages), please send it to the above address. Please call if further information would be helpful.

Clinician's signature

******* Patient's release of medical information *******

I Do ___ Do not ___ authorize Dr. _____ to release medical information that may relate to my mental health and/or substance abuse treatment to Dr. _____.

I Do ___ Do not ___ authorize Dr. _____ to share information relating to my mental health and/or substance abuse treatment, both of which are protected under confidentiality laws, to Dr. _____.

These authorizations are subject to revocation at any time, except to the extent action has already been taken on them, and will automatically expire one year from the date of signature.

signature of patient or guardian

date

