



WHITE OAK Counseling and Recovery

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Notification & Coordination with Primary Care Physician / Psychiatrist

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information

Client Name: _____

Client DOB: _____

Parent/Guardian (if applicable): _____

Physician Name/Clinic: _____

Phone #: _____ Fax #: _____

Current Psychiatric Services Yes or No

Treating Psychiatrist/Clinic: _____

List All Current Medications: *If more room needed, please attach separate sheet

Medication Name: _____ Dosage: _____ Reason: _____

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If it is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, White Oak Counseling and Recovery its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

Extent of information to be disclosed: Verbal Exchange or Written Summary or Other: _____

Signature of client, parent, guardian
and/or authorized representative

Date

Signature of Witness

Date

-----OR-----

My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

Signature of client, parent, guardian
and/or authorized representative

Date

Signature of Witness

Date

For Office Use Only:

Therapist Name: _____

Current Diagnosis: _____

White Oak Counseling and Recovery Staff – Faxed by: _____ Date: _____