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: _____
Medication Name: _____ Dosage: _____	Reason: _____
Medication Name: _____ Dosage: _____	Reason: _____

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:* _____