REPORT TO PRIMARY CARE PHYSICIAN FROM LICENSED MENTAL HEALTH PROVIDER

In accordance with federal statutes, this document has been authorized by the patient named below to allow me to communicate with you their diagnosis and treatment. This patient has identified you as their PCP and is aware of our efforts to coordinate their care.

Patient: _____ DOB: _____

Intake Date: _____ Next Visit Date: _____

Primary Care Physician: _____

Diagnostic Information:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Brief Treatment Plan:

_____

_____

Current Medication Concerns/Issues:

_____

_____

____ I understand that I have agreed to the release of information for collaborative care between my therapist at Coffee Counseling, Coaching, & Consulting (CCCC): Private Practice of Barbara Coffee, Ph.D., ABD, LMFT and the physician named above.

____ I refuse consultation between my primary care physician and my therapist at CCC.

_____ _____

Patient/Patient's Representative Signature **Date**

_____ _____

Therapist Signature **Date**