village
FAMILY PSYCHIATRY

Date: _____

Patient Name _____

SSN _____

Date of Birth _____

_____

Name of Primary Care Physician

_____

_____

Dear Dr. _____

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on _____ for treatment of

_____

_____

Current recommendations for the type and setting of treatment include:

[ ] Individual Psychotherapy
[ ] Family Psychotherapy
[ ] Group Psychotherapy
[ ] Electroconvulsive Therapy
[ ] Other _____
[ ] Medication Therapy (listed):

_____

_____

[ ] Outpatient
[ ] Intensive Outpatient Program
[ ] Partial Hospitalization Program
[ ] Inpatient Unit

[ ] Other pertinent communication:_____

_____

If you need any further information, please contact me at _____

Release for Coordination With Primary Care Physician:

For the purpose of coordinating care, my behavioral practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until sixty (60) days after my last date of treatment or until the time I revoke this release, which can be done at any time.

(Check One) I do ☐ I do **NOT** ☐ give permission to the practitioner named above to exchange information about my current treatment with my primary care physician.

Patient (Guardian) Signature

_____ Date _____

Signature of Witness

_____ Date _____

Sincerely,

_____ _____

Practitioner's Name Signature