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Behavioral Health Care and Coordination of Care Form

Patient Name:_____ Date of Birth_____
Primary Care Physician:_____
Address:_____
Phone number:_____ Fax number:_____

I, the above named patient, authorize Laurie Kimmel, LMSW, and my primary care physician, to exchange information regarding my mental health/ substance-abuse treatment and medical healthcare. This may include information relating to diagnosis, testing or treatment. I understand this authorization shall remain in effect for one year from the date signed and that I may revoke this authorization at any time by written notice.

Please select one: ___ I authorize communication with my PCP

___ I do not authorize communication with my PCP

By typing my signature on the line below I am agreeing that I have read, understand, and agree to the items contained in this document.

_____
Signature of Patient/Personal Representative Date

Treatment Recommendations

Diagnosis: _____

Treatment Recommendation: _____

_____

If you have any questions, please feel free to contact me.

Sincerely,