WellSpring Counseling Center Primary Care Physician Form

Please complete the highlighted lines:

____ Check here if patient does not have a Primary Care Physician

Primary Care Physician Name______________________________ Telephone #_________________

Address____

Dear Dr.________________________________,

Your patient, ________________________________, (DOB:______________) was seen at our office for outpatient counseling. We hope that the following information will be helpful in coordinating this patient's care.

Date of Initial Consultation_________________ Date of Next Appointment_________________

Diagnoses and/or brief description of presenting problem(s)______________________________

____

Treatment recommendations____
Please call if further information would be helpful.

WellSpring Counseling Center
1790 Town Park Boulevard, Suite C
Uniontown, Ohio 44685
Phone (330) 896-0856
Fax (330) 896-0887

Sincerely,

____
WellSpring Clinician

Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentially of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state of federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 6 months from the date signed.

I, ________________________________, hereby authorize ____.
(Print name of Patient if adult,
or Guardian's name if patient is a child)
WellSpring Clinician

Choose from the following:

____ To release any applicable information TO my primary care physician (as listed above)
____ NOT to release information to my primary care physician (as listed above)
____ To receive information FROM my primary care physician

Information requested from PCP:____

______________________________ (Signature of Patient or Guardian) ____________ (Date Signed) ______________________ (Witness) ___________ (Date Signed)