FAMILY LIVING INSTITUTE

Psychiatric and Counseling Services

757.229.7927

PRIMARY CARE PHYSICIAN (PCP) NOTIFICATION

FAMILY LIVING INSTITUTE
1307 JAMESTOWN RD SUITE 202, WILLIAMSBURG VA 23185
TELEPHONE: (757) 229-7927 FAX: (757)253-8891

AUTHORIZATION TO RELEASE 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 Confidentiality 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 federal regulations. I also understand that I may revoke my consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____hereby authorize Family Living Institute

(print patient's or guardian's name)

Please check one:

☐ To exchange the information listed below with the patient's primary care physician (PCP)

☐ PLEASE DO NOT RELEASE information to the patient's primary care physician (PCP)

*Patient's legal name (please print)_____Date of birth___/___/____

*Signature of patient or guardian_____ Date_____

*Relationship to patient (circle one): self parent guardian other_____

*Primary Care Physician's Name_____Tele. #_____

Fax #_____

_____Please do not write below line

Dear Dr._____this patient /family was recently seen in this office. I trust that the following will be helpful in coordinating this patient's care. I'll contact you in the future if there is information to share.

Patient's Name_____ Date of initial consultation_____

Provisional Diagnosis_____

Presenting Problem_____

_____

Treatment Recommendations/Plan/Follow-up

_____

Medications_____

Please call if any information will be helpful at this time

Provider_____

Signature_____Date_____

* Required information