HEADWATERS COUNSELING

Notification & Coordination with Primary Care Physician/Psychiatrist

AUTHORIZATION OF RELEASE AND/OR EXCHANGE OF INFORMATION

Client Name: _____ **Client DOB:** _____

Parent/Guardian (if applicable): _____

Physician Name/Clinic: _____

Phone #: _____ **Fax #:** _____

Current Psychiatric Services (●) **Yes** ( ) **No**

Treating Psychiatrist/Clinic: _____

Phone #: _____ **Fax #:** _____

List All Current Medications: *If more room is needed, please attach a separate sheet

Medication Name: _____ Dosage: _____ Reason: _____

Medication Name: _____ Dosage: _____ Reason: _____

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Medication Name: _____ Dosage: _____ Reason: _____

Medication Name: _____ Dosage: _____ Reason: _____

Medication Name: _____ Dosage: _____ Reason: _____

It is often helpful for your therapist to coordinate with your PCP/ Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP/ Psychiatrist Form.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information.

Redisclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed.

If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, Headwaters Counseling, its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

Extent of information to be disclosed:

☐ Verbal Exchange or Written Summary or ☐ Other: _____

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

OR

My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

_____	_____	_____	_____
Signature of client, parent, guardian and/or authorized representative	Date	Signature of Witness	Date

FOR OFFICE USE ONLY

Therapist Name: _____ Current Diagnosis: _____

Other Clinical Information:

_____

HW Administrative Staff – Faxed by: _____ On (date): _____

AUTHORIZATION FOR SCHEDULING, BILLING, AND PAYMENT PURPOSES

This form, when completed and signed by you (the client), authorizes the person(s) whom you have indicated below to call on your behalf for scheduling, billing and payment issues only. Your authorized person(s) will not be able to access information about your treatment or gain have the ability to gain access to the content of your confidential sessions with your therapist.

I authorize _____

Please indicate your relationship with this person below:
☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

I authorize _____

Please indicate your relationship with this person below:
☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

I authorize _____

Please indicate your relationship with this person below:
☐ Spouse ☐ Significant other ☐ Parent/Guardian ☐ Other: _____

- This authorization will expire once the purpose of this disclosure ceases to exist
- I understand that I have the right to revoke this authorization at any time by giving spoken or written notification to Headwaters Counseling

_____ _____
Signature of Client: Date: