HEALTH CARE COORDINATION FORM

Dear _____,

I wish to inform you that the patient identified below has been seen at Foothills Psychological Services, Inc. ***We are not requesting information from you at this*** time but would like to have this release of information in your records so that your treatment efforts can be coordinated as necessary. Please contact us in our Chino office at (909) 902-9111 or in Upland at (909) 946-4222 if additional information is needed.

Sincerely,

_____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ _____
Patient Name Date of Birth

I herby authorize the release of all medical, chemical dependency and mental health information necessary to coordinate the treatment I am receiving from the following providers:

_____ _____
Primary Care Physician Address

_____ _____
Psychiatrist Address

_____ _____
Psychologist or Psychotherapist Address

I understand authorizing the disclosure of information between my treatment providers is voluntary. This authorization becomes effective on the date signed and may be revoked by me at any time. If not earlier revoked, this authorization shall terminate automatically one year from today's date. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the information authorized by this release will be provided to the authorized recipients only and that these recipients are prohibited from further disclosure without my specific written consent. The information to be released may include my medical and psychiatric history, current condition, test results, diagnosis, medication and treatment plan. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Patient or Legal Guardian Date