

GrowthWorks Counseling, LLC  
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Health Care Coordination Form  
Consent for Release of Confidential Information to Primary Care Physician/Psychiatrist

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician or psychiatrist:

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

I understand that the release of this information is to permit my primary care physician or psychiatrist to monitor my mental health status and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me, in writing, at any time. If not earlier revoked, this authorization will terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. 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

Dear Dr. \_\_\_\_\_,

In order to coordinate care, I wish to inform you that your patient \_\_\_\_\_  
was referred to me for treatment on \_\_\_/\_\_\_/\_\_\_\_\_. The DSM-IV diagnosis is \_\_\_\_\_.  
Outpatient care is being delivered and the treatment plan consists of the following modalities:

- |   |  |
|---|--|
| <input type="checkbox"/> Individual Psychotherapy | <input type="checkbox"/> Couples Psychotherapy |
| <input type="checkbox"/> Family Psychotherapy     | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Group Psychotherapy      | <input type="checkbox"/> Other                 |

Medications are being managed by Dr. \_\_\_\_\_.  
Medications and dosages:

\_\_\_\_\_  
\_\_\_\_\_

If you need additional information, please feel free to contact me at 720-898-4769 or 720-979-9625.

Sincerely,

Amy Jones, MA, LPC  
GrowthWorks Counseling, LLC