Old Towne Counseling & Wellness

7489 Right Flank Road | Suite 330
Mechanicsville, VA 23116
Office: 804-398-8401 | Fax: 804-789-8881
Monday – Friday 9AM to 5:30PM

Physician Care Communication Form

Physician's Name: _____ **Phone: (____)**_____

Address: _____

RE: _____

Patient DOB: _____/_____/_____

Dear Dr. _____

Your patient, _____ has been seen in our office by:

_____

Date of initial assessment: _____/_____/_____
Next schedule appointment: _____/_____/_____

Diagnosis and/or Presenting Problem:

_____

_____

Treatment Recommendations:

_____

_____

If additional information is required; please, feel free to contact our office during regular business hours, Monday - Friday 9AM to 5PM.

Sincerely yours,

_____

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 Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provide for in state 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 expire _____/_____/_____, 12 months after first signed.

____**Yes**, I want this information released to my Primary Care Physician.
____ **No**, I do not want this information released to my Primary Care Physician.

Patient's signature: _____ **Date:** _____/_____/_____

Parent /Guardian signature: _____ **Date:** _____/_____/_____

Guardian Relationship to Patient: _____