Family Counseling Center
102 Marty Dr
Buffalo, Mn 55313
763-682-5420 phone 763-682-5803 fax

Physicians Release

Dear Client:

Physical and emotional issues often influence each other. To provide you with the most effective, coordinated care, physicians and therapists often need to communicate with one another and/or exchange records. In order to coordinate care with your physician/medical provider/clinic, we must have your written permission to do so.

Agreement to Release Information to Primary Care Physician:

If you agree to release information please complete back of this form:
including the areas with your name, your primary care provider's name and address, and your signature.

Decline to Release Information to Primary Care Physician:

If you do not want the Family Counseling Center to exchange information with your physician/medical provider, please check the appropriate line below and sign.

_____ I **do not** have a primary care physician/clinic

_____ I **do not** authorize the Family Counseling Center to communicate with my primary care physician/clinic.

Signature of patient/parent/guardian Date

(If you checked one of the above options to decline the release of information – then DO NOT fill out the back of this form)

LH:2008Rev

Consent for the Release of Information
To Coordinate Care with Primary Physicians

CLIENT INFORMATION

Client Name_____ DOB:_____

Client Address_____

PRIMARY PHYSICIAN INFORMATION	PROVIDER INFORMATION
Primary Physician Name and/or clinic _____ Office Address_____ _____ (City) (State) (Zip)	Provider Name The Family Counseling Center 102 Marty Drive Buffalo, MN 55313 (763)682-5420

Dear Doctor:
The above individual has sought mental health services at the Family Counseling Center. The following is her/his diagnosis and treatment plan.

Date of Assessment	Diagnosis
Current Symptoms	

Treatment Plan Includes:

___ Individual Therapy ___ Family Therapy ___ Referral to Support Groups
___ Couples Therapy ___ Psychiatric Consultation ___ Other _____

The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning client. The purpose of such release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions.

- ☐ Information contained on this form
- ☐ Assessment/Evaluation Report
- ☐ Discharge Summary and ITP (UBH Required)
- ☐ Discharge Report/Summaries
- ☐ Other (Describe)

This consent to release information shall expire, unless otherwise provided by state law, 12 months from date of signature.

x_____ _____ _____
Signature of Client/Legal Guardian Relationship to Client (if applicable) Date

x_____ _____
Signature of Adolescent Client Date

x_____ _____
Signature of Witness Date

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken upon it, by giving written notice to the parties above.