Behavioral Health/PCP Coordination of Care Form

Communication between behavioral health care providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

A. **PCP/Medical Practitioner or Other Ancillary/Behavioral Health Care Provider Information (including school, physical therapist, speech therapist, etc.):**

Name of PCP: _____

Address: _____

Phone: _____ Fax: _____

☐ I hereby consent to release information provided on this form about the above child to the PCP/Medical Practitioner identified above. I also give consent for the PCP/Medical Practitioner identified above to release medical records regarding the above child to Serving Children and Reaching Families, LLC. This consent will expire 1 year from the date of the above signature.

☐ I do not give consent for Serving Children and Reaching Families, LLC to coordinate care with my PCP, or other mental health care provider -checking this box means I am declining consent.

Office Use Only

B. **Behavioral Health Practitioner/Provider Information:**

Name: Serving Children and Reaching Families, LLC
1216 Patrick Street
Kissimmee, FL 34741

Phone: 321-236-1540
Fax: 321-594-6096

C. **Patient Clinical Information:**

The client is being treated for the following behavioral health diagnosis(es):

_____

Medications currently prescribed:

Treatment plan(s) or Recommendations:

Medical Follow-up Recommendation:

_____ _____

Client or Legal Guardian Signature Date