Spiritual Family Counseling, LLC.
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PRIMARY CARE PHYSICIAN NOTIFICATION FORM

THIS IS NOT A REQUEST FOR MEDICAL RECORDS. This form is used with your permission to notify your primary care provider that you are receiving therapeutic services.

ATTENTION PRIMARY CARE PHYSICIAN: Your patient is being seen at Spiritual Family Counseling, LLC. With patient authorization, we herein provide diagnoses, medications, and medication changes. Please retain for your records.

Patient name: ____
DSM-V diagnoses: ____
Treatment information: ____
____
Medications: ____
____
Clinician signature: ____ Date: _______________
Clinician printed name & credentials: ____

TO THE PATIENT: If you **DO** wish us to notify your primary care physician, please provide their name and address.
Primary care physician: ____
Clinic name: ____
Street address: ____
City, state, zip: ____
Phone: _____________________________________ Fax: ____________________________________

I, ____, (DOB: _____________________) hereby authorize Spiritual Family Counseling to exchange information regarding my mental and medical health treatment for the purpose of continuity of care, as may be necessary for the administration and provision of my health care coverage. Information exchanged will respect confidentiality of records in compliance with HIPAA regulations. I understand the authorization will remain in effect for one year or throughout treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to Spiritual Family Counseling. I also understand that is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

_________ I do not have a primary care doctor.
_________ I do not want my primary care doctor to know I am receiving services.
_________ I am not interested.

Patient/Guardian signature: ____ Date: ____________
Clinician signature: ____ Date: ____________