Coordination of Healthcare Services

To provide the highest quality of care, it is recommended that all treating providers share pertinent information regarding mutual patient's treatment. We request that you complete this form if you wish to authorize your behavioral health provider to exchange information regarding your Clinical Care Consultants' counseling services to your primary care provider or other behavioral health providers who may be directly involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission. You are not required to share this information and can check the appropriate box requesting that we do not contact your other treatment providers.

Client Name____ **Client Date of Birth**________________________

Please complete the following:

____ I **do not** give permission to communicate with other healthcare providers

____ I **do** give permission to contact the following health care providers (i.e. primary care, psychiatrists, school social workers, etc.)

1. Name____

Address ____

Phone ____

2. Name____

Address ____

Phone ____

3. Name____

Address ____

Phone ____

____ ____________________

Client Signature / (Legal guardian signature if under 18) **Date**