

Hardy & Stephens Counseling Associates, PLLC

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**PRIMARY CARE PROVIDER NOTIFICATION OF CLINICAL SERVICES
AND CONSENT FOR RELEASE OF INFORMATION**

Continuity and coordination between physical and mental health is an important aspect in the delivery of quality health care, as mental and physical disorders can interact to affect an individual's health.

PATIENT INFORMATION

PATIENT NAME

DATE OF BIRTH

INTAKE DATE

PRIMARY CARE PROVIDER INFORMATION

PRIMARY CARE PROVIDER/CLINIC

PHONE

FAX

ADDRESS

CITY/STATE/ZIP

MENTAL HEALTH PROVIDER INFORMATION

Dear Primary Care Provider,

I am sending this form to notify you that I am currently seeing your patient in a therapeutic setting and to provide our offices with release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.

Sincerely,

YOUR THERAPIST'S NAME

CLINICAL INFORMATION (Therapist will complete this section)

Reason for referral or care coordination:

Diagnosis: _____

Treatment plan(s) or recommendations: _____

CONSENT AND RELEASE

I authorize the exchange of information regarding my clinical care if needed to coordinate treatment with my primary care physician. I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the 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 (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for one year after last contact and I may cancel it in writing at any time.

SIGNATURE

DATE

REFUSE CONSENT AND AUTHORIZATION OF INFORMATION

I do NOT authorize information about my physical/mental health treatment to be released or exchanged with my primary care provider.

SIGNATURE

DATE