

**Patient Care communication Form
(Required if using insurance)**

Primary Care Physician name _____ phone # _____

Address _____

Dear Dr. _____

Your patient, _____, was recently referred by _____
We hope that the following information will be helpful in coordination this patient's care.

THIS SECTION IS TO BE FILLED OUT BY KATKIN & ASSOCIATES STAFF

Date of Initial Consultation _____ Date of Next Appointment _____

Diagnoses and /or presenting problems _____

Treatment Recommendations _____

Medications: _____

Please call if further information would be helpful.

Clinician's Printed Name _____

Address 5720-A Signal Hill Ct

Address Milford, OH 45150

Telephone Number (513) 831-9408

Sincerely,

Clinician Signature

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42CFR Part 2. A general information to criminally investigate or prosecute any alcohol or drug abuse patient.

AUTHORIZATION

I, _____ hereby authorize _____
PRINT PATIENT'S NAME PRINT TREATING CLINICIAN'S NAME

Please Check One: _____ To release any applicable mental health information to my primary care physician (PCP) named above.

_____ To release any applicable substance abuse information to my PCP named above.

_____ To release only medical information to my PCP named above.

_____ Not to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

SIGNATURE OF PATIENT OR GUARDIAN ID # DATE OF BIRTH