PROVIDER COMMUNICATION AUTHORIZATION FORM

Note: In order to offer the best and most comprehensive care, a therapist may need to contact a client's medical doctor to coordinate and exchange information, including the client's health records and history. This form grants permission for communication between the client's behavioral and medical health providers.

Client's name: _____ Birthdate: _____

Address: _____

City, State: _____ Zip: _____ Daytime Phone: _____

Insured By: _____ Plan ID#: _____

Provider Contact Information: [If you do not have a Medical Provider, check here: ____]

Medical Provider/Physician Name: _____

Address: _____

City, State: _____ Zip: _____ Phone: _____

Behavioral Provider/Therapist Name: Jane R. Dorlester, LCSW

Address: 293 Sixth Avenue

City, State: Brooklyn, NY Zip: 11215 Phone: 718-788-4991

Provider Diagnosis and Comments:
This section allows providers to communicate important information about the client to other provider(s).

Client Diagnosis: _____ Comments: _____

_____

Medications: _____ Comments: _____

_____

Risks/concerns: _____

_____

Client Authorization:
Signing this form is entirely voluntary. You do not need to sign this form to receive care or benefits. You have the right to revoke this authorization at any time by contacting your providers.

I, the undersigned, have read and understand the above information and give my authorization as follows:
(check all that apply)

___ To release any applicable medical information to my behavioral health provider/therapist.

___ To release any applicable mental health/substance abuse information to my medical provider/physician.

___ To release only medication information to my medical provider

___ I DO NOT give my authorization to release any information to my medical provider.

Client Signature: _____ **Date:** _____

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