Phone: 216-252-1399
Fax: 216-252-1409

14538 Grapeland Avenue
Cleveland, Ohio 44111

PATIENT CARE COMMUNICATION FORM
FOR PRIMARY CARE PHYSICIAN AND/OR REFERRING PHYSICIAN

AUTHORIZATION TO DISCLOSE INFORMATION

I hereby authorize the information below to be released to the following physician:

Physician's Name: _____

Address: _____

Phone: _____ Fax:_____

I understand that I may refuse to sign this authorization.

_____ _____
Patient's Name/Signature Date

_____ _____
Parent/Guardian Signature (if patient is under 18) Date

_____ _____
Witness Signature Date

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

To be completed by service provider:

Dear Physician:

Your patient, _____ (____-____-____), was recently referred to Daily Behavioral Health.
Name DOB

Presenting Problem:

Treatment Recommendation:

I hope this information is helpful to you in coordinating this patient's care. Please contact me if you have any questions or if any additional information would be helpful to you.

Sincerely,