Primary Care Physician Notification Form

THIS IS NOT A REQUEST FOR MEDICAL RECORDS!

Attention Primary Care Physician: Your patient is being seen at Mielke and Weeks Psychological Services. With patient authorization, we herein provide diagnoses and treatment information. Please retain for your records.

Patient Name: ____DOB:__________________

DSM-IV Diagnoses (Including Codes):

____

____

Treatment Information, including medications:

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Therapist/Psychiatrist Signature

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Print Therapist/Psychiatrist Name and Credentials

TO THE PATIENT:

If you **do** wish us to notify your primary care/family doctor that you are receiving services, please provide the complete name and address of your Primary Care Physician:

Primary Care Physician: ____Phone: ____________
Clinic Name (if any): ____Fax: ______________
Address: ____
City, State, Zip: ____

Please read and complete the following:

I, (print name here) ______________________________________ hereby **authorize** Mielke and Weeks Psychological Services to exchange information regarding **my/my child's (circle one)** mental health and/or substance abuse treatment and medical health care for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health care provider indicated herein. I also understand that it is my responsibility to notify by behavioral health care provider if I choose to change my primary care physician.

If you **do not** wish to authorize us to notify your primary care/family doctor, please complete the section below:

____ I don't have a primary care/family doctor.
____ I don't want my primary care/family doctor to know I'm receiving services.
____ I just don't want to.
____ Other____

____ _______________

Patient Signature (or Parent/Guardian if patient is a minor) Date

____ _______________

Witness Signature Date