**Counseling Associates, Inc**
6960 Orchard Lake Rd Suite 100
West Bloomfield, MI 48322
Phone – (248) 626-1500
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# Behavioral Health Care and Primary Care Physician Coordination of Care Form

**Patient Name:**_____ **Date of Birth:**_____

**Primary Care Physician:**_____

**Address:**_____

**Phone Number:**_____ **Fax Number:**_____

DATE MAILED OR FAXED TO PCP

I, the above named patient, authorize Counseling Associates, Inc and my primary care physician to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes, including information relating to diagnosis, testing or treatment. I understand that this authorization shall remain in effect for one year from the date signed and that I may revoke this authorization at any time by written notice.

Please select one: □ I authorize communication with my PCP

□ I do not authorize communication with my PCP

Signature of Patient / Personal Representative Date

INFORMATION BELOW TO BE COMPLETED BY PROVIDER

| **Diagnostic Impressions:** |
|---|
| |
| **Treatment Recommendations:** |
| |

If you have any questions, please feel free to contact me.

Sincerely,

Print Clinician Name / Credentials 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 any 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.