COORDINATION OF TREATMENT

FRIENDS COUNSELING
MARION | WABASH | KOKOMO

Behavioral Health (BH)/Primary Care Physician (PCP)

Client:	Date of Birth:
Address:	City, State, Zip:
Primary Care Physician (PCP):	Therapist:
PCP's Address :	Therapist's Address : **3563 South State Road 13**
PCP's City, State, Zip:	Therapist's City, State, Zip: **Wabash, IN 46992**
PCP's Phone #:	Therapist's Phone#: **(260) 563-8453**
PCP's Fax #:	Therapist's Fax #: **(260) 569-0335**
This form was filled out by:	
Please initial if you do not want the following protected health information released: Behavioral Health ___ Substance Abuse ___ HIV/AIDS ____	
I authorize the use and/or disclosure of my protected health information as described below. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. I understand that any health care provided by the primary care physician listed below will not be affected if I do not release information. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected. **(Accepted) Signature of Client or Guardian: _____ Date: _____** **(Declined) Signature of Client or Guardian: _____ Date: _____**	
Clinical Information: Diagnosis Code: _____ Date of Initial Appointment:_____ Focus of treatment: _____ _____ Medications Prescribed: N/A Labs/Tests Ordered: N/A	