Better Mental Health
Patient Care Communication Form

Improving Care Coordination Between Psychiatrists and Primary Care Physicians

Treating psychiatrist's contact information: ______________________________

Dear Dr. ____________________ Address: ______________________________

Your patient, ______________________________, was recently seen in our office. We hope that the following information will be helpful in this patient's care.

Date of visit: ____________ _____ Initial _____ Follow-up

Diagnosis and/or presenting problems: ______________________________

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Treatment recommendations: ______________________________

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Psychiatric Medications: ______________________________

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Laboratory needing to be followed: ______________________________

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If there is any medical information that may relate to the patient's mental health (chronic medical problems, allergies to medication, current medications and dosages), please send it to the above address. Please call if further information would be helpful.

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Clinician's Signature

Patient's release of medical information

I Do_____Do not_____ authorize Dr. ____________________ to release medical information that may relate to my mental health and/or substance abuse treatment to Dr. ____________________

I Do_____Do not_____ authorize Dr.____________________to share information relating to my mental health and/or substance abuse treatment, both of which are protected under confidentiality laws, to Dr. ____________________

These authorizations are subject to revocation at any time, except to the extent action has already been taken on them, and will automatically expire one year from the date of signature.

______________________________ ____________
Signature of Patient or Guardian Date