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Coordination of Care Communication Form

May I contact your Primary Care Physician? Yes _____ No _____ Date __________________________

Client Name ____ DOB ___________________

Primary Care Physician Name ___________________________________ Phone ____________________

Address ____

This information is provided to facilitate coordination of treatment/continuity of care. This client was seen by me on _____________________________________.

ICD-10 Diagnoses ____

The recommended treatment is ____

Please call me if you need to discuss this case further or if you require additional information.

Susan Sabol, Psy.D. ____
Licensed Psychologist

Client Authorization for Release of Information

I, ____, do hereby authorize Susan Sabol, Psy.D., to release and exchange medical/psychiatric and psychological information pertaining to me with my primary care physician. This authorization is for the exchange of information between the primary care physician and psychologist, and vice versa. This information will include diagnoses, treatment plan, tests, and medications. This authorization will expire no later than one year from the date of signature.

Client Signature ____ Date __________________

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