LIFELENS PSYCHOLOGICAL & COUNSELING SERVICES

PCP Contact Authorization **Account # ___________________**

PATIENT INFORMATION:

Name: ____
(first) (middle) (last)

DOB: ___________________ Social Security No. ________________________________

[ ] *I authorize* LifeLens Psychological & Counseling Services to release information to my Primary Care Physician: ____
Primary Care Physician Name

____
Address City Zip

____ ____
Office Number Fax Number

[ ] *I authorize* LifeLens Psychological & Counseling Services and my PCP to exchange information regarding my mental health treatment. The information exchanged may include diagnosis medications prescribed, and/or any medical concerns related to my care. The purpose of this disclosure is for coordination of care between LifeLens Psychological & Counseling Services and my physician. This release expires upon termination of my treatment with LifeLens Psychological & Counseling Services or upon my written request.

[ ] DO NOT AUTHORIZE THE RELEASE OF ANY INFORMATION TO MY PHYSICIAN

REASON: [ ] WILL NOTIFY DOCTOR MYSELF [ ] PRIVACY ISSUE

____ ____________________
(client signature) (date)

____ ____________________
(witness signature) (date)

////////////////////////////// Office Use Only ////////////////////////////////

Date Admitted / Assessed: ______________________________

Diagnosis: ____

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Type of Treatment and Frequency: [ ] Individual [ ] Family

[ ] Weekly [ ] Bi-weekly [ ] Monthly [ ] Other ____________________

Medical Concerns: _________ None Noted

____

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____ ____________________
Clinician printed name / signature date