Hoxworth Counseling Services
4695 N M37 Hwy, Suite A, Middleville, MI 49333
269-205-2402 ◆ Fax: 269-205-2728
Email: info@hoxworthcounseling.com ◆ Website: hoxworthcounseling.com

Notification & Coordination with Primary Care Physician / Psychiatrist

(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)

Authorization of Release/Exchange of Information

Client Name: **Client DOB:**

Parent/Guardian (if applicable):

Physician Name/Clinic: _____
Phone #: _____ Fax #: _____

Current Psychiatric Services ☐ **Yes or** ☐ **No**
Treating Psychiatrist/Clinic: _____

List All Current Medications: *If more room needed, please attach separate sheet
Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____
Medication Name: _____ Dosage: _____ Reason: _____

It is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

☐ I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, Hoxworth Counseling Services its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.
Extent of information to be disclosed: ☐ **Verbal Exchange or Written Summary or** ☐ **Other:** _____

_____ _____ _____ _____
Signature of client, parent, guardian and/or authorized representative | Date | Signature of Witness | Date

----------OR----------

☐ My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

_____ _____ _____ _____
Signature of client, parent, guardian and/or authorized representative | Date | Signature of Witness | Date

For Office Use Only:

Therapist Name: _____
Current Diagnosis: _____
_____
Hoxworth Counseling Services Staff – Faxed by: _____ *Date:* _____

Click to Submit completed form to Hoxworth Counseling