

DOMINION PSYCHIATRIC ASSOCIATES

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PRIMARY CARE RELEASE FORM

(Please Print)

Patient's Name: _____

Insured's ID Number: _____

Date of Birth: _____ / _____ / _____
(Month) (Date) (Year)

Employer's Name: _____

Patient's Address: _____

Primary Care Physician (PCP): _____

PCP Address: _____

Insured's Name: _____

Custodial Parent (if different than insured): _____

Release for coordination of care with my Primary Care Physician:

In order to coordinate care, my mental health provider may release pertinent information about my current treatment to my primary care physician. This release will be valid until sixty (60) days after my last date of treatment or until the time I revoke it, which can be done at any time. I understand that authorizing the disclosure of this information is voluntary.

(Please check one)

_____ I do
give permission to my mental health provider to release information about my current treatment to my primary care physician.

_____ I do not

(Patient or Guardian Signature)

(Witness Signature)

(Date)

(Date)

Initial Summary (to be completed by the provider):

Provider Name: _____

Date of Initial Visit: _____

Diagnosis (DSM-IV):

Axis I: _____

Axis IV: _____

Axis II: _____

Axis V (current): _____

Axis III: _____

Axis V (past year): _____

Current Medications: _____

Presenting Problems/Symptoms: _____

Treatment Plan/Recommendations: _____

Medications Prescribed: _____

(Provider Signature)

(Date)