3330 Claystone SE
Grand Rapids, MI 49546
Phone (616) 949-7460
Fax (616)949-3018

## COORDINATION OF CARE

Patient Name________________________________ Date of Birth____________________

Health Plan______________________________________________________________

I,____________________________________________ ☐ do authorize ☐ do not authorize
Print Client's Name

____________________________________________ my *behavioral health provider*,
Print Clinician's Name

and my *primary care physician*___________________________________________
Name primary care physician

__________________________________________________________________________
Address Phone Number

, to exchange information regarding my mental health/substance abuse treatment and medical healthcare; for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42 CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, which ever is longer. I understand that I may revoke this authorization at any time by written notice to my behavioral health provider. I also understand that it is my responsibility to notify this provider if I choose to change my Primary Care Physician.

____________________________________________ Date__________________
Client's (Parent or Guardian) Signature

____________________________________________ Date__________________
Clinician's Signature

**Behavioral Health Provider Information**
(To be completed by the clinician)

DSM IV Diagnosis Code and Name____________________________________________

Treatment Modalities
☐ Individual psychotherapy ☐ Group psychotherapy
☐ Family psychotherapy ☐ Medication treatment

Other________________ Frequency of Visits________________________________

Medications are managed by_______________________________________________
Physician's Name and phone number

| Date | Medication | Dosage | Date Discontinued |
|---|---|---|---|
| | | | |
| | | | |

Date sent to PCP_______________ Sent by_________________ Method ☐ Fax ☐ Mail