NYFS Northeast Youth & Family Services

PRIMARY CARE PHYSICIAN: RELEASE OF INFORMATION & CARE COORDINATION

CLIENT NAME: _____ DOB: _____ CASE # _____

Many insurance companies are requesting that Mental Health Providers have contact with a client's primary medical physician**.** It can be helpful to have this coordination given the link between physical and mental health. ***It is your choice whether or not to do this; you will not be treated any differently if you choose not to.***

Please select the option below that applies to you:

☐ NO, I do not want any communication with my medical doctor.

☐ NO, I do not have a medical doctor at this time. I understand I am encouraged to obtain one

☐ YES, I want you to notify my medical doctor that I am receiving care at Northeast Youth & Family Services. Please forward a letter notifying my medical doctor that I am receiving care at Northeast Youth & Family Services.

- HOSPITAL INFORMATION: Please provide NYFS on the line below with your preferred choice of hospital (s) if emergency transportation is needed.

If you have checked **YES to the above selections**, please complete:

AUTHORIZATION FOR RELEASE OF INFORMATION

Primary Care Provider: _____Clinic Affiliate:_____

Address: _____Phone: _____ FAX: _____

Covering the treatment period of: _____ to _____

I hereby give my permission to Northeast Youth & Family Services to exchange information regarding my case for the purposes of consultation and treatment planning with the above physician and/or clinic.

I understand that my clinical records are protected under State and Federal privacy regulations and cannot be disclosed without my written consent unless otherwise provided for by law. I understand that I may cancel this consent any time prior to the information being exchanged and that in any event, this consent form expires automatically 365 days after signing.

This authorization for disclosure of information has been fully explained to me and I understand it. I have been offered a copy of this form.

SIGNED: _____ DATE: _____
(Adult for Minor Client)

PRINT: _____
(Adult for Minor Client)

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