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Pediatric Neuropsychology
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Coordination of Care Form

Date: __/__/____ PCP Name: _____
Patient: _____ PCP Address: _____
Patient ID#: _____
DOB: _____

This information is provided to facilitate coordination of treatment/continuity of care. I saw this patient on __/__/__.

DSM IV Diagnosis: _____
_____

The recommended treatment regimen is _____

Please call me if you need to discuss this case further or if you require additional information.

_____ _____
Signature Name (Printed) Degree/License

Patient Authorization for Release of Information

I, _____, do hereby authorize _____ to release and exchange medical/psychiatric and psychological information pertaining to me/my child with my physician. This authorization is for the exchange of information between the physician and behavioral health clinician, and vice versa. This information will include information concerning diagnosis, treatment plan, tests, and medications. This authorization will expire no later than one year from the date of signature.

Signed: _____ Date: _____

Please do not contact my PCP at this time: _____

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR, Part 2) and/or state law. In accordance with Federal and State law requirements, the information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it

for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.