

Patient Care Communication Form

Physician's Name \_\_\_\_\_ Phone# \_\_\_\_\_ Fax# \_\_\_\_\_

Address \_\_\_\_\_

Dear Doctor \_\_\_\_\_ your patient \_\_\_\_\_ was recently seen in our office.

This information is for your records, should coordination of care be needed. Please call if further information would be helpful.

Clinician's Name: Dr. Gale Georgeff, MD Psychiatrist
Address: 8130 Adams Drive, Hummelstown PA, 17036
Phone Number: (717) 967-8288 Fax Number: (717) 967-8291

Sincerely,
Dr. Gale Georgeff, MD
Psychiatrist

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. 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 abuse patient.

AUTHORIZATION

I, \_\_\_\_\_ hereby authorize Cedar Valley Psychiatry to
Print Patient's Name

Please Check One: \_\_\_\_\_ Release any applicable medical/mental health information to my Primary Care Physician (PCP) named above.
\_\_\_\_\_ DO NOT to release any information to my PCP named above.

I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire one (1) year after I have terminated treatment.

Name of Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Office use only:

Communicated with the above provider has been completed for coordination of care.

Clinician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Notified by: Phone \_\_\_\_\_ or Fax \_\_\_\_\_

By: \_\_\_\_\_