C. Christopher Pawson, PCC
5210 Cherrington Rd
Toledo, OH 43623
419-318-4627 f 419-754-4117

Coordination of Care between Health Care Providers

Patient Name:_____ Date of Birth:_____ Today's Date: _____

Check one:

_____ Please communicate with my Primary Care Physician. (sign below)

_____ Please DO NOT communicate with my Primary Care Physician _____
Signature

Behavioral Health Provider:	***Primary Care Physician:***
C. Christopher Pawson, PCC *Professional Clinical Counselor* *5210 Cherrington Rd* *Toledo, OH 43623* *p:419-318-4627 f:419-754-4117*	*Name* _____ *Address* _____ *Phone*_____ *Fax* _____

Presenting Problem:_____

_____

Clinical Finding:_____

_____

Clinical Impression:_____

_____

Treatment and follow-up recommendations:_____

_____

Patient Consent to Disclose Medical Information

I, _____ , hereby expressly authorize the release and disclosure of all medical and counseling records, including but not limited to the types of information referenced above, to Dr. _____, for the purpose of coordinating my healthcare. I understand that my records are confidential and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.

_____ _____
Patient Signature Date

*This consent is valid for one year from the date of signature unless revoked in writing by the patient or legal guardian.