



# WHITE OAK Counseling and Recovery

4695 N M37 Hwy, Suite A, Middleville, MI 49333

phone: 269-205-2402 ♦ fax: 269-205-2728

e-mail: info@wocounseling-recovery.com ♦ website: wocounseling-recovery.com

## Notification & Coordination with Primary Care Physician / Psychiatrist

**(THIS IS A RELEASE OF INFORMATION FORM – NOT A REQUEST FOR MEDICAL RECORDS)**

### Authorization of Release/Exchange of Information

**Client Name:** \_\_\_\_\_

**Client DOB:** \_\_\_\_\_

Parent/Guardian (if applicable): \_\_\_\_\_

**Physician Name/Clinic:** \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

**Current Psychiatric Services**  Yes or  No

Treating Psychiatrist/Clinic: \_\_\_\_\_

**List All Current Medications: \*If more room needed, please attach separate sheet**

Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

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Medication Name: \_\_\_\_\_ Dosage: \_\_\_\_\_ Reason: \_\_\_\_\_

***If it is helpful for your therapist to coordinate with your PCP/Psychiatrist. Please indicate below whether you chose to give consent for the release of any or all information in this Coordination With PCP / Psychiatrist form.***

I acknowledge that information cannot be disclosed without my written informed consent unless otherwise provided by law. I understand I have the right to revoke this consent at any time; the revocation may be made verbally or in writing. Any information previously authorized and released cannot be subject to a revocation. HIPAA protects the privacy of health information. Re-disclosure of this information is prohibited by the Michigan Mental Health Code and also by Title 42 of the code of federal regulations. I understand that I am not required to sign this release/exchange of information and that I will not be denied services if I refuse to sign. I have a right to obtain a copy of the information disclosed. If no expressed or written revocation is issued, this authorization will expire one year from the date signed or at the termination of services.

### PLEASE CHOOSE AND SIGN ONE OF THE FOLLOWING:

I understand the information being released and exchanged. My signature indicates **my consent to release and exchange information** contained in this document with the physician/clinic identified above. I hereby authorize, White Oak Counseling and Recovery its director or designee, to release and/or exchange protected health information to the individual(s) or organization(s) listed above.

**Extent of information to be disclosed:**  Verbal Exchange or Written Summary or  Other: \_\_\_\_\_

\_\_\_\_\_  
Signature of client, parent, guardian  
and/or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

-----OR-----

My therapist has explained to me the importance of coordinating medical and mental health services. At this time, **I choose not to sign** a release for the exchange and release of information with my primary care physician.

\_\_\_\_\_  
Signature of client, parent, guardian  
and/or authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

### For Office Use Only:

Therapist Name: \_\_\_\_\_

Current Diagnosis: \_\_\_\_\_

White Oak Counseling and Recovery Staff – Faxed by: \_\_\_\_\_ Date: \_\_\_\_\_