Primary Care Coordination Form

Patient Name _____ Date of Birth _____

Address _____

THIS IS NOT A REQUEST FOR RECORDS

With my signature below I authorize Caroline Peterson, DC, PhD, MPH

To

□ Obtain □Disclose

Information to

Contact Person _____ Agency _____

Address _____

Telephone _____ Fax _____

Type of information to be disclosed for the purpose of coordination of care:

□Diagnosis □Medical Information □Psychological History

□Treatment Plan □Substance Use □Psychological Evaluation

□Other _____

Authorization

This authorization will remain in effect for the present course of treatment or until I revoke it. I know that I may end this authorization in writing at any time. I understand that the information disclosed as a result of this authorization may be subject to re-disclosure by the parties informed. I understand and agree to this disclosure of my protected health information,

Patient Signature _____ Date _____

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