
2020 Raybrook Ave SE, STE #305, Grand Rapids, MI 49546
Phone (616) 202-4444

**COORDINATION OF CARE
This allows us to communicate with your Primary Care Physician (PCP)**

**This document allows for the exchange of information regarding mental health/substance abuse treatment and medical healthcare; for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42 CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year from the date of my signature below, or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to my behavioral health provider. I also understand that it is my responsibility to notify this provider if I choose to change my Primary Care Physician.**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ do authorize do not authorize
 Print client’s name
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, my behavioral health provider,
 Print clinician’s name**

**And my primary care physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/Fax\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Name of primary care physician**

**To exchange information regarding mental health/substance abuse treatment and medical healthcare.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Address of PCP Phone Number of PCP**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Client’s (Parent or Guardian) Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Clinician’s Signature Date**

 **-------------------------------------Behavioral Health Provider Information-----------------------------------
 (to be completed by the clinician)**

 **Intake/Assessment attached Treatment Plan attached 90-day Treatment Plan Review**

**DSM V Diagnosis Code and Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Treatment Modality: Individual Group Family Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Basic Goals \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Identified stressors/barriers/strengths \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Progress toward goals: Initiating Improving Stable Declining

**Date sent to PCP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sent by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Mail**