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Primary Care Physician (PCP) Notification Letter *and* Authorization for exchange of Information with Primary Care Physician

This information is released for purposes of management and coordination of your medical and behavioral health care by your health care providers.

I, _____, hereby authorize _____with
(Patient or Patient's Guardian) *(Therapist)*

Michael Burke, Psy. D. & Associates., P.C. to disclose information checked below related to the treatment of _____, _____ to my PCP _____.
(Patient's Name) *(Patients DOB)*

_____ _____
(PCP Phone Number) *(PCP FAX)*

___Mental Health ___ Substance Abuse ___Medical Information including HIV/AIDS

This consent is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked this consent will termination one year from date signed or six months from date of discharge.

I understand that my records may include drug and/or alcohol abuse information, which is protected under the Federal Confidentiality regulations (42 CFR, Part 2). Any further disclosure of my records other than what is outlined above is prohibited without my specific written consent, or as otherwise permitted by such regulations.

Executed this _____ Day of _____ Year _____.

_____ _____
(Patient's Signature & Date signed) ***(Guardian's signature and date signed)***

Dear Primary Care Physician:

I have seen the above patient for outpatient counseling services. We look forward to coordinating care with your office! Please feel free to contact us at any time regarding this patient.

Thank you,
Michael Burke, Psy.D & Assoc., P.C.