Better Mental Health
Patient Care Communication Form

Improving Care Coordination Between Psychiatrists and Primary Care Physicians

Treating Psychiatrist's Information

Name: _____

Address: _____

Phone/Fax: _____

E-mail: _____

Dear Dr. _____

Your patient, _____, was recently seen in our office. We hope that the following information will be helpful in this patient's care.

Date of visit: _____ _____Initial _____Follow-up

Diagnosis and/or presenting problems: _____

_____

_____

Treatment recommendations: _____

_____

_____

Psychiatric Medications: _____

_____

_____

Laboratory needing to be followed: _____

_____

_____

If there is any medical information that may relate to the patient's mental health (chronic medical problems, allergies to medication, current medications and dosages), please send it to the above address. Please call if further information would be helpful.

_____
Clinician's Signature

Patient's release of medical information

I Do_____Do not_____ authorize Dr._____ to release medical information that may relate to my mental health and/or substance abuse treatment to Dr._____

I Do_____Do not_____ authorize Dr._____ to share information relating to my mental health and/or substance abuse treatment, both of which are protected under confidentiality laws, to Dr._____

These authorizations are subject to revocation at any time, except to the extent action has already been taken on them, and will automatically expire one year from the date of signature.

_____ _____
Signature of Patient or Guardian Date

Ohio Psychiatric Physicians Association
Ohio Academy of Family Physicians
American Academy of Pediatrics Dedicated to the Health of All Children™ Ohio Chapter
Ohio Osteopathic Association
Ohio ACOFP Ohio State Society of the American College of Osteopathic Family Physicians
Ohio Chapter ACP American College of Physicians Internal Medicine | Doctors for Adults