Physician Treatment Notification

Dear _____:
(Address/phone/fax)

This letter includes a release of information giving the Centers for Family Change and yourself permission to discuss a mutual patient who is in therapy at the Centers for Family Change.

Patient: _____ DOB: _____
Date of First Appointment: _____
Next Appointment scheduled for: _____

Patient reported problems with:

_____ depression	**_____ poor/excessive appetite**
_____ anxiety/panic attacks	**_____ poor/excessive sleep**
_____ emotional distress	**_____ poor concentration/focus**
_____ stress	**_____ behavior problems**
_____ suicidal ideation	**_____**
_____ substance abuse	**_____**

Diagnostic Impression:

This patient will be participating in:

_____ Individual therapy	**_____ Couples therapy**
_____ Family therapy	**_____ Play therapy**

Additional Comments:

Please contact me if you have any questions or additional information that you believe is important about this patient.

Sincerely,

_____ _____
Therapist signature Date
Centers for Family Change
Main phone: 630-586-0900 ext. _____

Request to release/obtain information from your Physician

_____ (initial by client) I hereby **consent: (complete section A, B and C)**
_____ (initial by client) I hereby **decline: (complete section A-**client & physician name-**and C)**

SECTION A: to have the **Centers for Family Change** release _____ (initial if consenting) and/or obtain _____ (initial if consenting) information regarding (patient's name) _____, DOB, _____,
To/from my physician: _____.

SECTION B: Complete section below only if authorizing release
I consent to disclosure of/request for the following specific information:

_____ Entire CFFC Treatment Record ____ Treatment Plan and Progress
_____ Psychological Testing Report ____ Psychiatric Records
_____ Medical Records (**PLEASE NOTE we do not need a copy of the patient's entire medical record; only information relevant to mental health treatment is requested**)
_____ Other (specify) _____

This disclosure is for the purpose of coordination of care. I understand that this consent can be revoked at any time by submitting a written and dated notice of revocation. I understand that Centers for Family Change (and its employees) cannot be held liable for any disclosures authorized by this release that occurred prior to the date of revocation.
I understand that unless revoked by written notice, this authorization of information is valid and binding for one year from the date signed.

SECTION C: Sign for Authorization and for Declining Authorization

Signature of client: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of others (those 12 or over who attended sessions): _____

_____

Witnessed by: _____ Date:_____