CHILD AND FAMILY PSYCHIATRIC CENTER
1744 E. McAndrews Rd., Suite B ▪ Medford, Oregon 97504
Phone (541) 776-0821 FAX (541) 776-5011
www.childandfamilypsychiatriccenter.com

COORDINATION WITH YOUR PRIMARY CARE PHYSICIAN

If you receive your medical care from a Primary Care Physician (PCP) I would like to coordinate the care and services I deliver here with the care and services you receive from your PCP. If you agree with this approach I will notify your PCP that you have entered treatment with me. Please sign to authorize the release of your initial intake diagnosis and treatment plan.

I hereby authorize:

Name: _____
Address: Child and Family Psychiatric Center
1744 E. McAndrews Rd., Suite B
Medford, Oregon 97504

To furnish/receive medical, psychiatric or psychological information from the records of:

Patient Name: _____ DOB: _____
To / From:
Name of PCP: _____ Phone: _____

Address: _____

_____

This release is effective from the date it is signed for the duration of treatment unless otherwise specified as follows: _____

I understand the the parties in receipt of these records may not further disclose the clinical information unless another authorization is obtained from me, or unless such disclosure is specifically required or permitted by law.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Authorized Person Date

_____
Relationship to Patient

CFPC/2015