Please complete this form ONLY if you would like us to inform your Physician of your visit today.

North Coast Family Foundation

West 130th St. Suite 500
Parma Heights, Ohio 44130
440.842.6867
Fax 440.842.8914

Dear Dr. _____ (Primary Care Physician) Date: _____

_____ _____ _____
Address City, State ZIP Code

_____ _____
Phone Number Fax Number

Your patient was recently evaluated at our office by _____. We hope the following information will be helpful for coordinating the patient's care:

Patient's Name:	
Date of Initial Consultation:	Date of Next Appointment:
Diagnosis/Problem:	
Recommendations:	

Please contact us if further information is necessary. Thank you. _____
Clinician's Signature

Patient Authorization to Disclose Information

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulation governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, _____ hereby authorize _____ to
Print Patient's Name Print Clinician's Name

Please check one:

- ○ Release any applicable information to my Physician
- ○ Do NOT release any information to my Physician Reason: _____

_____ _____
Print Patient's Name Patient's Date of Birth

_____ _____
Patient's Signature (or Guardian) Relationship to patient (if Guardian)