**Sage Tree Psychology Group LLC and Primary Care Physician Coordination of Care Form**

**Sage Tree Psychology Group LLC**

925 N Lapeer Rd STE 151

Oxford MI 48371

 Phone – (248) 303-1382

Fax – (248) 268-0128

|  |
| --- |
| DATE MAILED OR FAXED TO PCP   |

**Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, the above named patient, authorize Sage Tree Psychology Group LLC and my primary care physician to exchange information regarding my mental health/substance abuse treatment and medical healthcare for coordination of care purposes, including information relating to diagnosis, testing or treatment. I understand that this authorization shall remain in effect for one year from the date signed and that I may revoke this authorization at any time by written notice.

Please select one:□ I authorize communication with my PCP

 □ I do not authorize communication with my PCP

Signature of Patient / Personal Representative Date

INFORMATION BELOW TO BE COMPLETED BY PROVIDER

|  |
| --- |
| **Diagnostic Impressions:**  |
| **Treatment Recommendations:**  |

If you have any questions, please feel free to contact me.

Sincerely,

Print Clinician Name / Credentials Signature Date

**To the party receiving this information:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.