Primary Care Physician Communication Form

Client Name_____ Date of Birth _____

_____ I authorize the release of information to my Primary Care Physician.

_____ I do not authorize the release of information to my Primary Care Physician.

Client Signature _____ Date _____

Guardian Signature (If under 14) _____ Date _____

Witness_____ Date _____

This authorization will remain in effect until my case is closed. I have been informed that I have the right to revoke this consent at any time by written request, except to the extent that action has been taken in reliance on the authorization. I have been informed of my rights, subject to title 5100 of the Pennsylvania Mental Health Procedures Act to inspect the material released and of the confidentiality provisions of the Pennsylvania Drug and Alcohol Abuse Control Act and the Federal HIPAA regulations.

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PCP Name_____ Date Faxed_____

Phone _____ Fax _____ ☐ Initial Visit ***Please Call for Updates***

610-323-4673

Dear Doctor:

The above named client is receiving behavioral health services with LifeWorks Counseling Center, LLC.

ICD 10 Diagnosis

_____

Clinical Status/Communications to PCP

_____

_____

_____

_____

If you have any questions, please contact the office indicated below.

Therapist: _____ Date: _____

LifeWorks Counseling Center, LLC

933 North Charlotte Street, Suite 1-D

Pottstown, PA 19464

Phone: 610-323-4673 Fax: 610-323-4672

www.lifeworkscounselingcenter.net