HEALTHCARE COORDINATION

Sunny Hills Behavioral Health

Consent for Release of Confidential Information to Primary Care Physician

Patients Name:

First Name _____ **Last Name** _____ **Date of Birth** _____ **Member ID or SSN** _____

I hereby authorize release of the medical information listed below which pertains to my medical history, mental or physical conditions, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician. I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists

PRIMARY CARE PHYSICIAN (PCP)

_____

Address _____ **Phone Number** _____ **Fax Number** _____ **Date** _____

Signature of Patient or Legal Guardian

Dear Dr._____

In order to coordinate care,
I wish to inform you that your **patient**_____

was referred to me for
treatment on ____/____/____. The DSM-V code is _____.

Outpatient care is being
delivered and the treatment plans consists of Medication management.

Following Medication(s) are being managed by me.

Medications & Dosages:

1) _____ 2) _____

3) _____ 4) _____

If you need additional information, contact me at (714)773-4111.

Sincerely,

_____, M.D.

140 E. Commonwealth Ave., Suite 101 Fullerton, CA 92832, (714) 773-4111 www.sunnyhillsbh.com