HEATHER WILLIAMS, LMFT
LICENSED MARRIAGE & FAMILY THERAPIST

COORDINATION OF CARE WITH PRIMARY CARE PROVIDERS AND HEALTHCARE PROFESSIONALS

Patient Name _____

Date of Birth _____

Name of Patient's PCP _____

PCP's Phone # _____

I authorize the disclosure of confidential mental health information between Heather Williams and my Primary Healthcare Provider. I give permission for disclosure of diagnosis and treatment information about my child or me for the purpose of continuity of care. **I understand and expressly authorize the release of information related to any substance abuse or HIV status**.

This authorization is valid for one year and may be revoked by me in writing at any time.

Patient/ Legal Guardian
Signature _____ Date _____

OR

I **refuse** to authorize the release/ exchange of any behavioral health and medical information between Heather Williams and my (or my child's) Primary Healthcare Provider to promote the continuity of my (or my child's) behavioral health and general medical care.

Patient/ Legal Guardian
Signature _____ Date _____