NEUROBLOOM
PSYCHOLOGICAL CLINIC

PRIMARY CARE PHYSICIAN NOTIFICATION FORM

THIS IS NOT A REQUEST FOR MEDICAL RECORDS TO THE PATIENT

☐ **I DO NOT wish Neurobloom Psychological Clinic to notify my primary care/family doctor that I am receiving services**

☐ **I DO wish Neurobloom Psychological Clinic to notify my primary care/family doctor that I am receiving services.**

If you wish to notify your primary care physician, please provide :

Primary Care Physician: _____ Phone:_____

Name of Clinic:_____ Fax: _____

Address: _____

_____

Please read and complete the following:

I, _____, DOB _____ hereby authorize Neurobloom Psychological Clinic to exchange information regarding my mental health and/or substance abuse treatment and medical healthcare for the purpose of continuity of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care or substance abuse treatment as protected under 42 CFR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the behavioral health provider indicated herein. I also understand that it is my responsibility to notify my behavioral health care provider if I change my primary care physician.

_____ _____

Signature Patient/Parent/Guardian Date Witness Signature Date

ATTENTION: PRIMARY CARE PHYSICIAN

Your patient is a client at Neurobloom Psychological Clinic. With patient authorization, we are providing diagnoses and the therapist's contact information. Please retain for your records.

Patient Name: _____

DSM-IV Diagnoses (Including Codes): _____

Therapist Name and Credentials: _____