JULIE LANG, MFT
405 W. MAIN STREET
GRASS VALLEY, CA 95945
530-272-5521

Patient Care Communication Form

Dear Dr. _____:

I saw your patient, _____

Date of initial assessment_____

Diagnosis and/or presenting problem_____

_____

Treatment Recommendations_____

_____

_____

Please call if further information would be helpful.

Sincerely,

_____

Authorization to Disclose Information

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 CPR Part 2, prohibit you from making 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.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CPR PART 2.

____ I want this information released to my physician.

____ I do not want this information released to my physician.

REASON:_____

Patient's Signature_____ Date _____

Parent/Guardian Signature_____ Date _____

Witness Signature _____ Date _____