

**CORNERSTONE PSYCHOLOGICAL SERVICES**  
**4018 Medina Rd Ste D, Medina, Ohio 44256**  
**330-722-4166**

**PATIENT CARE COMMUNICATION FORM**

*(Top section to be completed by client)*

**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 CFR 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.

\_\_\_\_\_ I **want** this information released to my physician

\_\_\_\_\_ I **do not want** this information released to my physician

Print Patient's Name \_\_\_\_\_

Patient/Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**Physician's Name:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone # (required) \_\_\_\_\_ fax# \_\_\_\_\_

\*\*\*\*\*

*(To be completed by therapist)*

Dear Dr. \_\_\_\_\_

Your patient, \_\_\_\_\_, SS# \_\_\_\_\_ DOB: \_\_\_\_\_ was recently referred to Cornerstone. We hope that the following information will be helpful in coordinating this patients care.

**CHIEF COMPLAINT:**

\_\_\_\_\_  
\_\_\_\_\_

**FINDINGS / PATIENT**

**STATUS:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**DIAGNOSIS:** \_\_\_\_\_

**PLAN:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Sincerely,

\_\_\_\_\_  
Therapist Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date