CORNERSTONE PSYCHOLOGICAL SERVICES
4018 MEDINA RD. STE. D, MEDINA, OHIO 44256
330-722-4166

PATIENT CARE COMMUNICATION FORM

(*This 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#_____

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(Bottom Portion 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