Behavioral Health/Medical Provider Coordination of Care

Please complete this form so we may communicate with your Primary Care Physician or other medical provider. If you do not have a physician, or do not want to disclose information to any medical provider, please check the appropriate box at the bottom and sign.

CLIENT INFORMATION

Client's name (person being seen for counseling):	Birth date:	Age:
If client is a minor, parent's or guardian's name:		Daytime phone no:
Client's home address:		

Client Authorization:
I understand that I am not required to sign this authorization as a condition of receiving services from Banyan Counseling Network. The reason for disclosure is to facilitate continuity and coordination of treatment and may include the diagnosis of mental health disorders. I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. In any event, this consent shall expire one (1) year from the date signed unless revoked earlier. Expiration date: _____

PRIMAY CARE PHYSICIAN OR MEDICAL PROVIDER

☐ Client does not have a medical provider.

PCP or Medical Provider:	PCP or Medical Provider phone no:
PCP or Medical Provider Address:	PCP or Medical Provider fax no:

I give my authorization (check all that apply):

☐ To release any applicable mental health information to my PCP and/or medical provider designated above.

☐ To release any applicable medical information from my PCP and/or medical provider to my behavioral health provider.

I DO NOT give my authorization:

☐ To release any information to my PCP and/or medical provider.

Client or Parent/Guardian Signature: _____ Date: _____
If I am signing as a parent or guardian of a minor child, I further understand that the information released may contain references to myself and family.

BEHAVIORAL HEALTH PROVIDER COMMUNICATION

Therapist Name: Cynthia R. Carter, M.S., LPC, LMFT	Address: 14525 FM 529, Suite 200 Houston, TX 77095	Phone no: (281) 746-3406
Client Diagnosis:	Comments:	
Risks/Concerns:	Comments:	

***To the party receiving this information**: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of information is not sufficient for this purpose.*