Mass Bay Counseling

**234 Copeland St., 3rd Floor, Quincy, MA 02169**

## Patient Care Communication Form

Primary Physician's
Name_____Telephone_____Fax_____

Address_____City_____State____Zip_____

E-Mail Address_____

Dear Dr._____

Your patient: _____Date of Birth _____

Was seen by_____

Date of initial assessment: _____ Next appointment:_____

Diagnosis and/or presenting problem: _____

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TREATMENT RECOMMENDATIONS: _____

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Medication (if applicable) _____

Please call if further information would be helpful.
Sincerely,

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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.

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

___I want this information released to my physician.
___I do not want this information released to my physician.

Patient's Signature_____Date_____

Parent/Guardian Signature_____Date_____

Witness Signature_____Date_____

**Quincy**
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