From the Office of Judith Smithchild
M.Ed, LPCC-S, LICDC-S, NCC, ICADC-S
17 Blue Line Drive Athens, Ohio 45701
(740) 592-5689 (740) 593-7166

Release/Exchange of Behavioral and Medical Care Information and Report Form

Client/Patient Name: _____ DOB: _____ Age: _____

Client Address: _____

PCP/Health Care Provider Name: _____

Address: _____

Phone: _____ Fax: _____

I hereby given permission of my private behavioral health care information, including diagnosis and plan of care, to be **released to** my medical care provider and permission also for the **receipt of** medical health care information, including diagnosis and medication list, from my medical care provider for the purpose of coordination of behavioral care and medical health care services for the duration of my care at this office**. Initials: _____**

Client signature: _____ **Date: _____**

I hereby revoke this release of information effective this date. Signature:_____ Date: _____

BEHAVIORAL HEALTH CARE REPORT SECTION

Admission Date: _____ Number of attended sessions: _____ Cancellations: _____

Primary Diagnosis: _____

Service Plan Goals: _____

Planned Services: _____

Interventions: _____

Expected Duration of Services: _____

Referrals made: _____

MEDICAL CARE INFORMATION REQUEST SECTION

Please provide the following to this office:
Admission Date
Diagnosis
Medication List
Any recommendations

Signature: _____ Date: _____