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Release for Coordination with Primary Care Physician (PCP)

Patient name (printed) _____Birthday_____

Patient address _____

Name of PCP _____

Address and phone number of PCP:

_____

For the purpose of coordinating care, my dietitian may wish to exchange pertinent information about my current treatment with my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Patient signature_____

or Patient Representative's signature (if applicable) _____

Date_____

If you do not wish any information to be exchanged with your primary care physician, sign below.

I do NOT give permission to the practitioner named above to exchange information about my current treatment with my primary care physician. SIGNATURE IS REQUIRED

Patient or patient representative's signature_____

Date _____ Witness signature _____

If you do not have a primary care physician, sign below.

I do not have a PCP.

Patient or patient representative's signature _____

Date_____