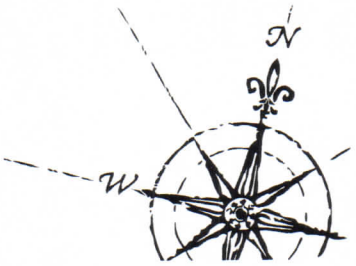

Counseling Northwest

Health Care Coordination Form

Mill Creek Office Park
16000 Bothell-Everett Hwy Ste. 270
Mill Creek, WA 98012

Mailing Address:
16212 Bothell-Everett Highway
PMB #131
Mill Creek, WA 98012

(To the Client: Please fill out information below:

Consent for Release of Information to Physician or Other Health Care Provider:

Patient Name: _____ **Birth Date:** _____

Physician/Health Care Provider Name _____

Office Address _____

Phone/Fax Number _____

I hereby authorize Matthew R. Evich and my Health Care Provider to share information pertaining to my medical history, medications, mental health issues, substance abuse issues, treatment plan, and for other relevant information. I understand that only the minimal amount of information necessary for treatment will be shared and that the purpose is to help both health care providers coordinate care and provide higher standards of treatment. This authorization may be revoked at any time.

_____ **I agree to share information with my physician/health care provider and medical staff.**

_____ **I decline to share information with my physician/health care provider and medical staff.**

_____ _____

Signature of Patient or Legal Guardian **Date**

.....

Dear _____,

In order to better coordinate patient care and treatment, I am communicating information with you regarding your patient named above. The initial appointment was on _____ and the client is being treated for _____.

The treatment plan consists of outpatient psychotherapy. Following are goals of treatment, etc.:

_____

_____.

Please feel free to contact me if you have questions. **I would appreciate any new referrals.**

Matthew R. Evich, MA, LMHC

Phone: 360-840-1903 • Fax: 425-337-2608
www.counselingnw.com • Email: mevich@comcast.net