41400 Dequindre, Suite 110
Sterling Heights, MI 48314
Phone 586.580.2975
Fax 586.580.2954
www.SilverLiningsPLLC.com

COORDINATION OF CARE

Attention (Doctor's name/Clinic name): _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Fax: _____

Your patient:_____ Date of Birth: _____
is being seen at Silver Linings Counseling and has authorized us to coordinate care with you. Below is information regarding the treatment we are providing to your patient. **This is *not* a request for records.**

To be Completed by Clinician

DSM V Diagnosis and Code: _____

_____

Treatment Recommendations: _____

_____

Provider's Name/Credentials: _____

To be Completed by Client

Please select an option below by initialing the line next your selection.

_____ I, _____, hereby authorize Silver Linings Counseling to exchange information regarding my mental health and/or substance abuse treatment and medical health care for the purpose of coordination of care as may be necessary for the administration and provision of my health care coverage. Information exchanged may include information on mental health care of substance abuse treatment as protected under 42 CPR Part 2 (respecting substance abuse records) and/or state laws respecting confidentiality of records and patient communications with health care providers and in compliance with HIPAA regulations. I understand that this authorization shall remain in effect for year. I understand that I may revoke this authorization at any time and I must do so in writing to my mental health care provider. I also understand it is my responsibility to notify my mental health care provider if I choose to change my primary care doctor.

_____ I do not authorize Silver Linings Counseling to provide to or exchange any personal health information with my primary care/family doctor.

Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____