

**Free To Be**

**Mental Health Services, LLC**

**Primary Care/Other HealthCare Provider Communication Form**

Please complete this form if you would like our office to inform your other providers that you are being treated by Free To Be Mental Health Services, LLC:

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Provider Office (Primary Care, Therapist, OB/GYN, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This letter is to inform other members of my treatment team that I am receiving services at Free To Be Mental Health Services for:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[Symptoms or Diagnosis]:

I plan to receive the following treatments while in the care of Free To Be Mental Health Services, LLC:

\_\_\_\_ Therapy

\_\_\_\_ Medication to reduce mental health symptoms

\_\_\_\_ Both

I give Free To Be Mental Health Services, LLC and the providers’ offices, listed above, permission to share my private health information with each other. This consent does not expire until I submit written request to terminate communication.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider or Staff Signature: Date: