2727 Electric Road, Suite 103
Roanoke, VA 24018

Physicians Release

Dear Client:

Physical and emotional issues often influence each other. To provide you with the most effective, coordinated care, physicians and therapists often need to communicate with one another and/or exchange records. To coordinate care with your physician/medical provider/clinic, we must have your written permission to do so.

Agreement to Release Information to Primary Care Physician:

If you agree to release information please complete page 2 of this Physicians Release:
including the areas with your name, your primary care provider's name and address, and your signature.

Decline to Release Information to Primary Care Physician:
If you do not want the Roanoke Valley Counseling Center, LLC to exchange information with your physician/medical provider, please check the appropriate line below and sign.
_____ I **do not** have a primary care physician/clinic
_____ I **do not** authorize the Roanoke Valley Counseling Center, LLC to communicate with my primary care physician/clinic.

_________________________________ _________________________
Signature of patient/parent/guardian Date

(If you checked one of the above options to decline the release of information – then DO NOT fill out the back of this form)

LH:2008Rev

Physicians Release (p.2)

Consent for the Release of Information
To Coordinate Care with Primary Physicians

<table>
<tr><td colspan="2">CLIENT INFORMATION</td></tr>
<tr><td colspan="2">Client Name: ____ DOB: __________________

Client Address: ____</td></tr>
<tr><td>PRIMARY PHYSICIAN INFORMATION</td><td>PROVIDER INFORMATION</td></tr>
<tr><td>Primary Physician Name and/or clinic
____

Office Address____

____
(City) (State) (Zip)</td><td>Roanoke Valley Counseling Center, LLC
3243 Electric Road, Suite 2B
Roanoke, VA 24018
(540) 355-8578</td></tr>
</table>

Dear Doctor:
The above individual has sought mental health services at the Roanoke Valley Counseling Center, LLC. The following is her/his diagnosis and treatment plan.

Date of Assessment: _______________________________

Diagnosis ____

Current Symptoms: ____

Treatment Plan Includes:
___ Individual Therapy
___ Family Therapy
___ Referral to Support Groups
___ Couples Therapy
___ Psychiatric Consultation
___ Other _______________________________

<table>
<tr><td>The undersigned authorizes the provider and primary physician to release/obtain the following medical records and information concerning client. The purpose of such release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions.</td></tr>
<tr><td>☐ Information contained on this form ☐ Assessment/Evaluation Report
☐ Discharge Summary and ITP (UBH Required) ☐ Discharge Report/Summaries
☐ Other (Describe)
This consent to release information shall expire, unless otherwise provided by state law, 12 months from date of signature.</td></tr>
<tr><td>x____ _______________________________ ________________
Signature of Client/Legal Guardian Relationship to Client (if applicable) Date</td></tr>
<tr><td>x____ _________________
Signature of Adolescent Client Date</td></tr>
</table>

I understand that I have the right to inspect and copy the information to be disclosed. I understand that my records may be protected under the Federal Confidentiality Regulations (42CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken upon it, by giving written notice to the parties above.