Counseling & Health Center

317 West "F" Street Ontario, CA 91762
Phone: (909) 391-3051 / Direct: (714) 325-5621 / Fax: (909) 391-3068

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I have received Notice of Privacy Practices, and understand that Counseling & Health Center has certain legal duties to safeguard my Protected Health Information (PHI). I also understand that I have certain rights in regard to my (PHI).

Patient or Guardian's Signature

Date Picker

HEALTH CARE COORDINATION FORM

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

First Name | **Middle Name / MI** | **Last Name** | **Date of Birth**

I hereby authorize the release of the medical information listed below which pertains to my medical history, mental or physical condition, or treatment, including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment to my primary care physician:

Physician Name | **Phone Number** | **Fax Number**

Address | **City** | **State** | **Zip**

I understand that the release of this information is to permit my primary care physician to monitor my health status and to coordinate all the care, which I may receive from specialists. I further understand that I have a right to receive a copy of this authorization upon my request. This authorization becomes effective on the date signed and may be revoked by me at anytime, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me.

Signature of Patient or Legal Guardian

Date

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