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PHONE 251.342.4707 | FAX 251.342.4724
EMAIL | PSYCHNFP@GMAIL.COM

N. Faye Pierce, Ph.D.

Patient Care Communication Form

Physician's Name: _____ Telephone: _____

Address: _____ City _____ ST_____ ZIP _____

Dear Dr. _____:

Your patient, _____, was seen by _____

Date of initial assessment: _____ Next appointment: _____

Diagnosis and/or presenting problem: _____

_____

Treatment Recommendations: _____

_____

Medication (if applicable): _____

Please call if further information is needed.

Sincerely,

N. Faye Pierce, PhD., FPPR

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. General regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2

_____ I want this information released to my physician.

_____ I do not want this information released to my physician.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____Date: _____