PATIENT CARE COMMUNICATION FORM

Name of Primary Care Physician____
Address: ____
City: ____________________ State: __________ Zip Code: ______________
Phone: ____________________ Fax: ____________________

Dear Dr.______________________________:

Your patient, ______________________________, has been seen by me in my office on (initial assessment) __________. The next appointment is ____________.
Diagnosis and/or presenting problem is: ______________________________
____
Treatment recommendations: ______________________________
____
____
Medication(s) prescribed: ______________________________
____
____
Please call if you have any additional questions or concerns.

Sincerely,

Shailesh Gandhi, M.D.
Child, Adolescent & Adult Psychiatry
6555 Sugarloaf Parkway
Ste. 307-258
Duluth, GA 30097

Phone: 770-277-7195
Fax: 888-747-9242

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that my records are protected under the applicable state laws governing healthcare information that relates to mental health services and that, under the federal regulations governing Confidentiality of Alcohol/Drug Abuse, Patient Records 42 CRF Part 2, my records cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at anytime except to the extent that action has been taken already. This release expires one year from the date signed.

_____ I want this information released to my Primary Physician
_____ I do not want this information released to my Primary Physician

Patient's Signature: ______________________________ Date: __________

Parents/Guardian Signature: ______________________________ Date: __________

Witnessed by: ______________________________ Date: __________