Quantum Counseling Inc.

COORDINATION OF TREAMENT

It is important that all health care providers work together. Therefore, we would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for one year. ***Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we have acted in reliance on such authorization****. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s) ____I decline to inform my physician

I, _____, authorize

Quantum Counseling Inc. and its representatives to release or exchange information concerning me from/to:

PHYSICIAN NAME:_____
CLINIC:_____
ADDRESS:_____
PHONE:_____

Information to be release or exchanged may include:

_x___Psycho-social History	__x___Discharge summary
_x___Treatment Plan	__x___Treatment recommendations
____Educational/vocational history	_____Diagnostic Testing
_x___Treatment Progress	_____Health History
_x___Substance use history	_____Physical/lab exam results
_x___Psychiatric evaluation	___x__Mental status
_x___Diagnosis	___x___Attendance

For the purpose of:

__x__Completing Evaluation	___x___Coordination of Services
____Submission for Billing/Insurance	_____Other

If not withdrawn, this authorization expires on _____.

Client Signature(s)_____Date_____

Parent/Guardian Signature(s)_____Date_____

Witness Signature(s)_____Date_____