North Kent Guidance and Testing Services

5250 Northland Drive NE, Ste. A
Grand Rapids, MI 49525
(616)361-5001

106 S Greenville West Drive, Ste 3
Greenville, MI 48838
(616)754-2364

Client Consent to Exchange Information with Primary Care Physician

CLIENT NAME:_____
Date of Birth:_____

I _____authorize
(please print)
the behavioral health provider_____
and my primary care physician, Dr._____Phone#_____fax#_____
Address:_____
_____

to exchange information regarding my mental health/substance abuse treatment and medical health care for coordination of care purposes as may be necessary for the administration and provision of my health care coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral health care provider. I also understand that it is my responsibility to notify my behavioral health care provider if I choose to change my primary care physician.

Signature:_____Date:_____

Signature of parent/guardian_____Date:_____

This section to be completed by behavioral health provider.

DSM 5 Diagnosis code & name:_____

Treatment Plan: Type_____ Frequency_____ Est. length of TX_____

Comments:_____

_____

Signed:_____Date:_____

COPY OF THIS FORM SHOULD BE SENT TO THE PRIMARY CARE PHYSICIAN,RETAINING THE ORIGINAL IN THE CLIENT RECORD.