The Counseling and Cooperative Parenting Center of Ohio, LLC
CCPC · OHIO
8559 S. Mason Montgomery Rd, Mason, OH 45040
P: 513-229-8980 F: 513-229-8935 ccpc-ohio.com

CLIENT CARE COMMUNICATION FORM

Client Name: ____ **Date of Birth:** __________________

☐ **I DO NOT** wish the Primary Care Physician (PCP) for this client be contacted at this time. ***(Note: Some insurance companies require that your mental health provider share basic information with your (PCP) regarding your treatment. Refusal to allow this information to be released may result in your insurance company denying coverage for services rendered.)***

(This can be changed any time you choose in the future.)

\- OR -

☐**I DO** wish the Primary Care Physician (PCP) for this client be contacted at this time and have completed the below information to be FAXED to the following PCP:

FAX TRANSMITTAL

To: ____ Company: ________________________________
(Primary Care Physician)
Phone Number: ______________________________ Fax Number: _______________________________

Consent to Release Patient Information to Primary Care Physician to Coordinate Care

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with this provider. If the purpose for seeing CCPC-Ohio is to generate a report to a court and/or other third party(ies), then failure to sign the authorization releasing the information to the court and/or third party(ies) may result in CCPC-Ohio refusing to see you.

Dear Doctor,

The aforementioned client has entered into therapy with me at The Counseling & Cooperative Parenting Center of Ohio, LLC. The following information is being shared with you for the purpose of continuity of care:

Presenting Problem:____
Treatment Plan Recommendations:____
Medications Prescribed, Per Client Report:____

Other pertinent information regarding my treatment, diagnosis, behavioral, mental and emotional functioning and behavioral health status, may be shared with you in the future (except progress notes) on an as needed basis.

FYI: NO ACTION IS REQUIRED ON THE PART OF THE RECIPIENT, NOTE TO RECIPIENT OF INFORMATION: This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. However, once the information is released by CCPC-Ohio, it may be redisclosed by the recipient of the information and no longer protected.

BY SIGNING BELOW, I INDICATE THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.
I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. If I do not revoke this authorization, it will expire (1) year after I have terminated treatment with this provider.

____ __________________
Client /Parent/Guardian **Date**

____ __________________
CCPC-Ohio (Therapist) **Date**