RIVERPOINT PSYCHIATRIC ASSOCIATES
155 Kingsley Lane, Suite 320
Norfolk, Va. 23505
Phone (757) 489-4700 Fax (757) 489-0240

Patient name: _____ Birth date: _____ ID/Member #: _____

Today's Date: _____

To: Primary Care Physician: _____
Address: _____
_____
Phone #: _____ Fax #: _____

Dear Dr.: _____

In an effort to coordinate care, I am informing you that your patient (named above) was seen by me on _____ for (diagnosis code) _____. **This is NOT a request for records, simply a notice that the patient has been seen (in the interest of coordination of care). Please contact us if you desire further information.**

Current recommendations for the type and setting of treatment include:

( ) Individual therapy
( ) Family therapy
( ) Inpatient treatment
( ) Medication therapy (listed below):
_____

( ) Outpatient
( ) Intensive outpatient program
( ) Partial Hospital Program
( ) Other _____

If you need further information, please contact me at (757) 489-4700

Sincerely

( ) Burt Segal, LCSW
( ) Raleigh Phillips, Psy.D.
( ) Karen Hazen, PhD, LPC
( ) Anne C. Abraham, LCSW
( ) Paul Callis, PA
( ) Huma Hyder, MD
( ) Jennifer Cooke, PA-C
( ) Timothy C. Taylor, LCSW
( ) Angel Williams-Kent, FNP-C

Release for coordination of treatment with primary care physician

For the purpose of coordinating care, my behavioral health care practitioner may wish to release pertinent information about my current treatment to my primary care physician. I hereby authorize the use or disclosure of my individually identifiable health information. This release shall be valid until sixty (60) days after my last date of treatment or until the time I revoke this release, which can be done at any time.

(Check one) I do ( ) / I do not ( ) give permission to the practitioner specified above to release information about my current treatment to my primary care physician.

Patient signature (Guardian, if patient a minor) _____
Witness signature _____