Behavioral Health Patient Summary Form

Referring and Consulting Providers: Please use this form to enhance coordination of care for your patient. You can complete this form online and distribute it electronically or print and distribute it by paper. Please complete the form below with your contact information and communication preferences.

Patient Information			
First Name	MI	Last Name	Birthdate
Allergies			

Request				
To				Date of Request
From				Phone Number
Street Address				Fax Number
City	State	ZIP	Email Address	
Communication Preference	☐ Phone	☐ Fax	☐ Mail	☐ Email
Reason for Request				
Relevant Clinical Data				

Consultation Report

Clinical Evaluation and Diagnostic Tests

Clinical Impression/Diagnosis

Medication Therapy

Treatment Plan

Follow-up

Authorization

I, ______________________________________, hereby expressly authorize ___________________________________ [insert name of disclosing provider] to release and disclose all medical and counseling records associated with the symptoms referenced in this Patient Summary Form to _____________________________________ [insert name of receiving provider], for the purpose of coordinating my healthcare. I understand my records are confidential and cannot be disclosed without my written consent, unless otherwise provided for in state or federal regulations. I understand that I may revoke my consent in writing at any time, but this will not affect any information that has already been shared, or any actions taken by those who have that information. If I do not revoke consent, it will terminate on _______________________________ [insert termination date].

Signature (Patient or Legal Guardian)	Print Name (Patient or Legal Guardian)	Date