



Ann Arbor Consultation Services

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Release of Information to Primary Care Physician

I, _____ hereby DO* DO NOT authorize Ann Arbor Consultation
(CLIENT NAME) (CHECK ONE)
Services (AACS) to release information contained in my client record to my Primary Care Physician (PCP) and
for my PCP to release information to AACS. If consent is provided, information will be released as follows:

1. Type of Information to be disclosed: assessment &/or treatment information
2. This consent is subject to revocation at any time except to the extent that the program which is to
make the disclosure has already taken action in reliance upon this release. This release will terminate on:

- A. Date: _____
- B. Event: 6 months after date of my discharge from Ann Arbor Consultation Services
- C. Condition: _____

Witness

Client Signature (or parent/guardian)

Date Witnessed

Date Signed

*I understand that my consent to release information will include sending of the information below to my PCP, as well as treatment updates, discharge
information (e.g. a summary of my treatment) and any other information deemed necessary to coordinate my treatment at Ann Arbor Consultation Services.
I understand that this release is reciprocal, meaning that it also permits my PCP to send/communicate information to Ann Arbor Consultation Services.

Initial Patient Care Communication to Primary Care Physician

Name of Patient: _____ (DOB) _____
PLEASE PRINT

Dr: _____ Phone: _____

Address: _____ Fax: _____

AACS USE ONLY

Date of Assessment ____/____/____ DSM-IV Diagnosis: _____

- Patient Has been referred to the psychiatric service at our clinic (consult report forthcoming)
 Has been referred to you for initial &/or continued treatment with psychiatric medication(s)
 Has declined referral for psychiatric medication treatment
 Will attempt behavioral health interventions before a psychiatric medication trial
 Will receive behavioral health treatment only

Behavioral Health Treatment Plan Information

Type of therapy CBT (Cognitive Behavioral Therapy) DBT (Dialectical Behavior Therapy)
 IPT (Interpersonal Therapy) Dynamic Therapy Other

Modality Individual Group Couples Family

Frequency Weekly Biweekly _____ Estimated Treatment Completion Date ____/____/____

Please contact me with any questions or comments Mailed Faxed on _____
(DATE)

Behavioral Health Provider Name & Credentials X Phone Ext Behavioral Health Provider's Signature

Under federal and state law, re-disclosure of this information may require the authorization of the patient to whom the information pertains, or his/her personal representative (e.g., legal guardian, parent of a minor child). Please consider the need for written authorization before you re-disclose any of this information. 05.27.2009