Pittington Counseling Services

Building Stronger Lives Together
One Step At A Time

Authorization and Consent for Communication with Primary Care Physician

I understand that in signing this Authorization and Consent for communication between Pittington Counseling Services and Primary Care Provider, that I am agreeing to participate with my primary care provider (PCP) in a comprehensive approach to medical care. This communication is intended to promote information sharing between patients and their PCP care team so that everyone has a complete picture of existing and potential health risks for the purpose of producing better health outcomes. Pittington Counseling Services may communicate with my PCP, other physicians/practitioners, specialists to whom I am referred for care or from whom I receive care, and other healthcare professionals involved in the treatment or prevention of medical conditions.

Additionally, this agreement may be terminated by either party at anytime due to dissatisfaction or other reasons. A copy of this Authorization and Consent extends to information placed in my medical file after the effective date of this Authorization and Consent.

Check one: ☐ Patient Agrees ☐ Patient Declines

Patient Name (printed):_____ Date: _____

Patient Signature: _____

Parent/Guardian Signature: _____

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