Care Coordination Consent

I, _____ (insert patient name), hereby expressly authorize _____ (insert name of disclosing provider) to release and disclose all medical and counseling records 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

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