Who is your primary care doctor (PCP)? ____

Address and/or clinic name: ____

City:___________________________________ Phone: __________________________________

May I contact your PCP to coordinate care? If yes, please sign and date at the bottom of the page:

CONSENT TO RELEASE Confidential Information

I, hereby authorize **Lynne Coon, L.P.C.** to exchange information about:

____

(Name) (Date of Birth)

with ____

(Agency and/or Individual)

Extent of information to be disclosed:

____

Purpose of this disclosure of information:__Coordination of care______________________

____

____

I may revoke this release, in writing at any time, except to the extent of action that has already been taken.

Date, event, or condition upon which this release expires:

____

It is understood that the information specified above will not be released to any third party agency or individual without my knowledge and consent. State laws (ORS 192.500, ORS 179.505) and federal law (HIPAA, Pub protect the confidentiality of this information L. No. 104 – 191, 1996).

____

Signature Date