PSYCHOLOGICAL CARE ASSOCIATES @ CHILDREN'S MEDICAL OFFICE of North Andover, P.C.

We supplied this Release of Information & Treatment Summary form to our patient in order to facilitate clinical collaboration and coordination of care. If you are new to this patient's treatment, we would appreciate a communication of your findings and intended treatment plan. If the patient is in ongoing care, a summary and status report would be appreciated. If our office can be of any help, please let us know. Thank you in advance for your assistance.

Please fax or return in a timely manner to: **Children's Medical Office**
477 Andover Street
North Andover, MA 01845
Fax: 978.975.7409

Authorization to Release Protected Health Information: To aid in the coordination of my or my dependent's care, I do hereby authorize the release or disclosure of my or my dependent's protected health information, including opinions, to Psychological Care Associates @ Children's Medical Office:

Clinician Name:_____ License:_____

Address: _____

Email: _____ Tel:_____

I retain the right to revoke this authorization at any time. This authorization will remain in effect until termination of treatment with the above-named clinician/practice or _____, whichever is sooner.

_____ _____
Patient Name (**Printed**) Date of Birth:

_____ _____
Patient Signature (Parent or guardian if a minor or dependent) Today's Date

_____ _____
Parent / Guardian Name (**Printed**) Relationship to Patient

Treatment Summary & Status:

Date 1st Seen:_____ Date Last Seen:_____ Visit Duration & Frequency:_____

Chief Complaint(s): _____

Diagnoses:_____

Rule Outs:_____

Treatment Interventions Planned or Provided:_____

_____

Treatment response: _____

_____

Factors influencing treatment response: _____

Medication Plan: _____

If you will be considering a medication consultation, to whom do you routinely refer?

_____

Other Referrals under consideration:_____