



**Report to Primary Care Physician from Licensed Clinical
Mental Health Provider**

In accordance with Kansas Statutes, this document has been authorized by the patient named below to allow me to communicate with you their diagnosis and treatment. This patient has identified you as their PCP and is aware of our efforts to coordinate their care.

Patient: _____ DOB: _____

Intake Date _____ Next Visit Date _____

Primary Care Physician _____

Diagnostic Information:

AXIS I: _____

AXIS II: _____

AXIS III: _____

AXIS IV: _____

AXIS V: _____

Brief Treatment Plan:

Current Medication Concerns/Issues:

____I understand that I have agreed to the release of information for collaborative care between my therapist at Veridian Behavioral Health and the physician named above.

____I refuse consultation between my primary care physician and my therapist at Veridian Behavioral Health.

Patient/Patient's Representative Signature

Date

Therapist Signature

Date