F. Michael Montgomery, LCSW, LMFT

1209 College Avenue • Santa Rosa, California 95404 • (707) 578-9385

E-mail: fmm@inner-healing.com • Web: www.inner-healing.com • Fax: (707) 578-9271

Therapy for the heart, mind, body and spirit in a safe and healing setting

Primary Care Physician Request For Mental Health Information

Your Primary Care Physician's Name (please print): _____

Client Section

Legally, clients have the option to (check one):

- ☐ Receive a copy of this Request for Mental Health Information.
- ☐ Waive the requirement to receive a copy of this Request for Mental Health Information.
- ☐ Request that no mental health information be provided to your primary care physician.

_____ _____

Client Signature Date

To _____ (primary care physician),

Clinician Section

I, F. Michael Montgomery, LCSW, MFT, am currently providing mental health services for your patient _____. If you wish to discuss their mental health diagnosis and treatment plan with me, please return this Request for Mental Health Information to me at the following address or fax it to me at (707) 578-9271.

F. Michael Montgomery, LCSW, MFT
1209 College Avenue
Santa Rosa, CA 95404

_____ _____

Clinician Signature Date

Primary Care Physician Section

To protect patients from broad disclosure of personal information, I am requesting only the following limited information about the above referenced person.

1. The specific information available to be released is: current symptoms, diagnosis, and treatment plan.
2. We intend to use this information for coordination of care.
3. The information you supply will not be used for any purpose other than its intended use.

_____ _____

PCP Signature Date