Colony Care Behavioral Health
11 River Street Wellesley, MA 02481

COORDINATION OF BEHAVIORAL HEALTH CARE

Please complete this form so that your Colony Care Provider can notify your (or your child's) Primary Care Provider (PCP).

Provider Name and Address:

_____ Date: _____

_____ Phone: _____

_____ Fax: _____

Regarding: (patient) _____Date of Birth: _____

Release of Information Authorization: I do authorize the exchange of information between my PCP, or my daughter's/son's PCP, and the Colony Care Mental Health Provider listed below.

Signature of patient or parent Guardian: _____

To be completed by CCBH clinician

Dear _____:

I am writing to inform you that your patient, _____, has begun counseling services here at Colony Care Behavioral Health. If you have questions or information you would feel would be helpful, please feel free to contact me. Leave a message on my voicemail if you care to or a phone number at which I can contact you.

Sincerely,

_____ (Provider Signature)

_____ (Provider Name)

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11 River Street, Wellesley, MA 02481
Phone: 781.431.1177, Extension_____
Fax: 781.431.1181

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