**Gem Moore, PhD  
Foxcroft Psychological Services  
2723 Foxcroft, Little Rock, AR 72227**

**CONSENT FOR COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Patient Making Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Doctor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Doctor Location/Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I acknowledge that this mental healthcare facility, in accordance with their Notice of Privacy Practices (NOPP) and the Omnibus HIPAA law, will release Patient Health Information derived from my treatment records to the physician listed above. I have reviewed the NOPP of this mental healthcare facility and have been given an opportunity to ask questions about it, understand it, and agree to its terms. A copy of this signed, dated consent shall be effective as the original.

I release, hold harmless, and agree to indemnify this mental healthcare facility, its employees, and its agents for any and all liability (including but not limited to negligence) arising out of or occurring under this Consent.

I specifically authorize this mental healthcare facility to use and disclose verbally, by mail, fax, or encrypted email the following type of super-confidential information as stated in the NOPP:

**\_\_\_\_\_\_\_\_\_\_\_** Psychotherapy Records  
 **(Initial)**

I also understand that I may withdraw my consent at any time by informing this office in writing.

**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

-OR-

Representative’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Representative Name (Please Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_