Behavioral Health Affiliates, LLC

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Coordination of Care

We at Behavioral Health Affiliates have a strong commitment to integrated medical and mental health services. To achieve this goal, we request that you give us your permission to coordinate your care.

I, ______________________________ give Behavioral Health Affiliates, LLC my permission to discuss my care with:

- ☐ My primary care provider: ________________________________

  Address: ____

  Phone Number: ____________________

- ☐ Other treating clinicians within Behavioral Health Affiliates

____________________________ ____________________

Signature of Patient Date

____________________________ ____________________

Signature of Treating Clinician Date