Confidential Report of Primary Care

Patient Name: **Date of Birth:**	**From: Francine Owens, LCSW**
To:	**26 Lamar Circle Suite 5** **Jackson, TN 38305**
City: **State:** **Zip:**	**Phone: (731) 660-5279**

The above named patient was recently referred to me at Owens Family Counseling for mental health services.

I hereby request and authorize the named provider/facility to release the medical information described below to my PCP/Center.

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Patient's Signature

Note: If patient requests information not to be released to PCP/Center, patient must sign here:

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My findings include the following

Date of Visit: ______________________________

DSM-V-TR Diagnosis:

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Treatment Plans/Recommendations:

☐ Individual Counseling
☐ Group Counseling
☐ Family Counseling
☐ Substance Abuse Counseling
☐ Medication Management
☐ Other

Medication:______________________________________

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Other Pertinent Information:______________________________

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