# HEALTH CARE COORDINATION FORM

## Authorization for Disclosure of Health Information

I hereby authorize: Dale Beaman, Ph.D

250 W. First Street, 242, Claremont, CA 91711 (909) 621-9023

To Coordinate Care with any of the following:

| Primary Care Physician | |
|---|---|
| Address | |
| Telephone | |
| Fax | |

| Psychiatrist | |
|---|---|
| Address | |
| Telephone | |
| Fax | |

| Psychologist/Therapist | |
|---|---|
| Address | |
| Telephone | |
| Fax | |

The purpose of disclosure is to coordinate my health care services by providing the information regarding your therapy, which may include: assessment, diagnosis, and treatment plan. This authorization shall become effective immediately and shall remain in effect until (date):
______________________________________________________________________________

I understand that any requests to revise or cancel this authorization must be in writing; that I can request a copy of this signed release; that the recipient of this information may not further use or disclose unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law; and that treatment cannot be conditioned based upon signing this authorization.

______________________________________________________________________________

Print Patient Name Signature

______________________________________________________________________________

Witness Signature Date