Venture Forthe, Inc.
Patient Care Communication Form
Ph. 716-501-8123
Fax. 716-501-8234

Physician's Name _____Phone #_____

Address _____ City_____ State _____ Zip_____

Dear Dr. _____:

This is to inform you that your patient, _____, is being seen by Venture Forthe for one or more home and community based behavioral health services, based on his or her mental health and/or substance use disorder diagnosis. Please feel free to provide any recommendations you have in their treatment. If you have any questions or concerns, please contact us at your convenience.

Thank you!

Sincerely,

Venture Forthe, Inc.

_____ _____
Signature Phone

Authorization to Disclose Information

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations 42 CFR Part 2 prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2.

I understand I may revoke my consent in writing at any time except to the extent that action has already been taken in reliance on it.

Patient, please check one:

☐ I agree to release this information to my physician listed above.

☐ I do not agree to release this information to my physician listed above. (Reason_____)

☐ I do not have a physician.

Patient Signature _____Date _____

Parent/Guardian Signature _____ Date _____