Please Print

SAHARA BEHAVIORAL HEALTH

Satinder S. Purewal, M.D. LLC.
6677 W. Thunderbird Rd., Suite 1-164
Glendale, AZ 85306
Phone: 623-878-2100 Fax: 623-776-9419

Health Care Coordination Form

Patient Name _____ DOB _____

Member ID Number or Social Security Number _____ - _____ - _____

I hereby authorize, **Sahara Behavioral Health,** the release of all clinical/medical and mental information about me which pertains to my medical history, medications, mental and physical condition, and/or treatment, and my mental health diagnosis and treatment of substance abuse to my Primary Care Physician.

☐ I do not have a Primary Care Physician at this time.

_____
Primary Care Physician Name

_____
Address

_____ _____
Phone Number Fax Number

I understand that the release information is to permit my primary care physician to monitor my health status and to coordinate all the care which I may receive from specialists. This authorization becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to this recipient only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____
Signature of Patient or Legal Guardian Date

_____ _____
Witness Signature Date