Fax: 321-639-1194
referrals@impowerfl.org

PRIMARY CARE PHYSICIAN NOTIFICATION

IMPOWER, is a non-profit organization that provides counseling and psychiatric services. As an agency, we are working to coordinate services with the primary care physician and other providers to ensure that our clients are receiving coordination of care. Please see below and send us the pertinent information that is requested by the client. *Please advise of any charges before sending records.*

Client Name:_____ Date of Birth:_____

Primary Care Physician		
To:	Primary Care Doctor:	
	Address:	
	City, State, ZIP:	
	Phone:	Fax:
Requests regarding physical health concerns		
☑ Please send records regarding any physical conditions that can impact mental health.		

Comments (optional):

_____

_____

_____

I hereby give permission for a copy of this form to be faxed or mailed to the above-named Primary Care Physician.

Thank you for your time and collaboration,

_____ _____

Client or Legal Guardian Signature Date