

(Community Support Provider Letterhead)

_____(Date)_____:

_____(Consumer's Name & Date Of Birth)_____ is currently receiving community support/mental health services from our agency.

- This patient has identified you as their Primary Medical Provider. *If this is not accurate information please contact us.*

- The following information is enclosed:
 - Mental health diagnoses
 - Current medications & Prescriber's name
 - Relevant lab work

- If we can be of any assistance to you regarding this patient, please contact the case manager listed below.

Primary Case Manager: _____

Phone Number: _____

➤ ***A Release of Medical Information is enclosed. In order for us to best serve this patient, we are requesting the following medical information from you:***

- Updated Problem/Medical Diagnoses List
- Updated Medications List
- Known Allergy List
- _____

Please send the above requested information to (Community Support Provider Fax #) _____.