RECOVERY TECHNOLOGY L.L.C.

Primary Physician Coordination of Care Form

Doctor: _____ Date: _____

Address: _____

City/State/Zip: _____

Re: _____ DOB _____

Dear Dr. _____

This is to inform you that the above-named patient has had the following change in treatment:

☐ Hospitalization ☐ Crisis Home Placement ☐ Other: _____

Receiving the following services:

☐ Outpatient Mental Health Therapy
☐ Substance Abuse Therapy
☐ Assertive Community Treatment
☐ Integrated Dual Disorder Treatment
☐ Dialectical Behavior Therapy
☐ Case Management

Request information from you:

☐ Most current lab results
☐ Diagnosis that you are treating
☐ Most recent physical exam results
☐ Immunization Records
☐ Medications being prescribed by you
☐ Other: _____

The Patient's Diagnosis is: _____

_____

_____

_____

☐ THIS PERSON QUALIFIES AS A MEDICALLY INDIGENT INDIVIDUAL AS DEFINED IN SECTION 106 OF THE SOCIAL WELFARE ACT." MCL § 333.26263(K)

THE SOCIAL WELFARE ACT DEFINES A "MEDICALLY INDIGENT INDIVIDUAL" AS "[A]N INDIVIDUAL RECEIVING FAMILY INDEPENDENCE PROGRAM BENEFITS OR AN INDIVIDUAL RECEIVING SUPPLEMENTAL SECURITY INCOME . . ."

MICHIGAN'S MEDICAL RECORDS ACCESS ACT, PROVIDES THAT "A HEALTH CARE PROVIDER, HEALTH FACILITY, OR MEDICAL RECORDS COMPANY SHALL WAIVE ALL FEES FOR A MEDICALLY INDIGENT INDIVIDUAL." MCL § 333.26269(E)(3).

The patient has signed a release allowing further contact between us. Please feel free to contact me for any questions or coordination of care.

Clinician: _____ Phone Number: _____
(please print)

Clinician Signature/Credentials: _____