HOMETOWN PASTORAL COUNSELING GROUP PLC

****Please note that this is NOT a request for medical records****

Coordination of Care Letter

Re: Client: _____ Client DOB: _____

Dear _____, in accordance with the current guidelines for Coordination of Care established by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the Virginia Department of Medical Assistance (DMAS), we are required to inform you the above named individual is receiving counseling services at Hometown Pastoral Counseling Group.

The above-named client reported symptoms that I believe are consistent with the diagnosis of _____. This client has signed an authorization form, allowing us to exchange pertinent information with you. if you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

Treating Provider Information Name: _____

Phone: (540)879-6106 Fax: (540)908-3268

Address: 7 Killdeer Ln, Ste B. Dayton, VA 22821

Respectfully,

HTPCG Staff Signature and Credentials Date

Revised 2/1/2022