COORDINATION OF MEDICAL SERVICES

In order to provide the highest quality of care, we ask that you approve or deny permission to communicate with additional providers involved in your healthcare.

Please complete the following:

Client Name ____Date of Birth______________Gender_____________

___ **I do not give permission** to communicate with my other healthcare providers.

___ **I give permission** to contact the following providers, e.g. primary care, psychiatrists, pediatricians, etc…

1. Name____

   Practice____

   Address____

   Phone____

2. Name____

   Practice____

   Address____

   Phone____

Client's Signature____Date_________________

Parent's Signature____ Date_________________
(If client is under 18 years old)

For Therapist Use:

____ New referral by physician (If more than one physician above, please note which is the referring physician.)

____ New referral not by physician

____ Current client

Additional information to include in physician collaboration letter:

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Therapist name ___________________________________