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 <u>not</u> 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_____ Email_____

2. Name_____

   Practice_____

   Address_____

   Phone_____ Email_____

Client's Signature_____Date_____

Guardian'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 <u>not</u> by physician

____ Current client

Additional information to include in physician collaboration letter:

_____

_____

_____

Therapist name _____