NOTIFICATION OF TREATMENT TO PRIMARY CARE PHYSICIAN FOR COORDINATION OF CARE

I understand that the information authorized by this release will be provided to the authorized recipient only. Additional information may be provided to those recipients only with signed consent from me.

☐ I (Client Signature) _____ do not give my permission to send this letter to my Primary Care Physician for coordination of care.
Date:_____

☐ I (Client Signature) _____ give my permission to send this letter to my Primary Care Physician, for coordination of care.
Date: _____

Physician's Name: _____

Address: _____

Phone: _____ Fax: _____

RE (Client Name): _____(please print)

Date of Birth:_____

Dear Doctor,

This is to inform you that I am providing professional mental health services to the above named client. I have received authorization to inform you of this. If you desire additional information about this client please contact me at (505) 271-5050.

Sincerely,

_____
Provider Signature

_____
(Please print name) Sent: _____

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