



**RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN (PCP)**

Your PCP is the medical representative responsible for coordination of your total care. Therefore it is appropriate for him or her to be aware of the behavioral therapy taking place under my care. With your permission, I would like to communicate basic treatment information to your PCP after your initial evaluation. Any further communication will require additional permission.

**Please initial the appropriate statement:**

\_\_\_\_\_ **Please DO NOT contact my PCP after my initial session.**

\_\_\_\_\_ **Please DO contact my PCP after my initial session.**

**My PCP is** \_\_\_\_\_

**Address :** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_