PROFESSIONAL CONTACTS

1.

a) I (do/do not) want my primary care physician to be notified that I am receiving therapy at Williamsburg Center For Therapy.

_____ _____

Signature Date

b) If so,do you want your therapist to coordinate treatment with _____ _____M.D. by verbal or written communication? (Yes____ No____)

c) If yes, please sign the authorization for release of information after it has been filled out by your therapist or his/her designee.

2. a) I (do/do not) want my therapist to contact and thank my professional referral source (e.g., therapist, clergy) for referring me to therapy/counseling and to let him/her know that I have begun to work on changing myself/life.

_____ _____

Signature Date

Therapist name_____ Phone_____

b) If yes, please sign the authorization for release of information after it has been filled out by your therapist or his/her designee.