The Center
for Christian Counseling, Consultation & Training, Inc.

4868 High Crossing Blvd.
Madison, WI 53704
608.274.8294
608.274.8783 Fax

CONSENT FOR RELEASE OF INFORMATION WITH PRIMARY CARE MEDICAL PROVIDER

I, _____, _____ **authorize** or **do not authorize**
Client Name DOB (Circle one)

an exchange of information about my treatment (*including form below*) at The Center for Christian Counseling, Consultation and Training, Inc. with my primary care physician or provider listed below. (This authorization expires one year from today)

_____ _____
Primary Care Provider (last name, first) Clinic Affiliation

_____ _____
Clinic Address City, State Zip

Phone _____ Fax _____

_____ _____
Client / Legal Representative Signature Date

_____ _____
Witness Date

Dear _____,

The above listed client was last seen in my office on _____.

Client diagnosis is _____.

My treatment recommendations are _____

_____.

Next session has been scheduled for: _____.

Please contact me at (608) 274-8294 with any questions you may have regarding the treatment recommendations or treatment progress.

_____ _____
Therapist Name Therapist Signature