

RELEASE OF REPORT TO PRIMARY CARE PHYSICIAN

Please check one:

- I **do not** give permission for Hamburg Counseling Service, Inc. to release my mental health information to my Primary Care Physician.
- I give my permission to, Hamburg Counseling Service, Inc., to release mental health information regarding my treatment to my Primary Care Physician: Dr _____ for the purpose of facilitating coordination of care. I understand that I have the right to revoke this release at any time. This release shall be valid until ninety days after my last day of treatment or until I revoke this release.

PRIMARY CARE DOCTOR: _____

STREET ADDRESS: _____

CITY: _____ ZIP: _____

PHONE #: _____ FAX #: _____

CLIENT SIGNATURE

DATE

WITNESS

DATE