Susan Chamberlin, LMHC
28 Green St.
Newbury, MA 01951

PLEASE PRINT ADDRESS BELOW

_____ Primary Care Physician
_____ Organization
_____ Address
_____ City, State, Zip

Primary Care Physician Communication Form

I, _____ hereby authorize my
PRINT CLIENT'S NAME DATE OF BIRTH

therapist, Susan Chamberlin, LMHC, to release to my Primary Care Physician:

Please check one: _____ only the information on this page (start date and diagnosis including substance diagnosis if applicable)

_____ no information

I understand that this authorization is voluntary and that I have the right to refuse to disclose this information. I understand that my healthcare and payment of my healthcare will not be affected by this form.

_____ _____
SIGNATURE OF CLIENT OR GUARDIAN DATE

OFFICE USE:

Date treatment initiated: _____

Diagnosis: _____

_____

PROVIDER NAME: _____

Prohibition on redisclosure

To persons receiving released information: This information had been disclosed to you from records protected by federal regulation which prevents you from any further disclosures without specific written consent of the person to whom it pertains.