

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 _____

CITY

STATE

ZIP

PHONE: _____ FAX: _____

SIGNATURE: _____ DATE: _____

NANCY A. UMPHRES, LPC, LMFT
6750 HILLCREST PLAZA DRIVE
SUITE 307
DALLAS, TX 75230
PHONE AND FAX: 972-233-9067