THE PSYCHOLOGY CLINIC, Inc.

CONSENT FOR RELEASE OF INFORMATION WITH PRIMARY CARE PHYSICIAN

I, _____, _____,
Client Name DOB

☐ **Authorize**
☐ **Do Not Authorize**

an exchange of information about my treatment at The Psychology Clinic with my primary care physician or provider listed below:

_____ _____
Primary Care Physician/Provider Clinic Affiliation

_____ _____
Clinic Address Clinic Phone#/Fax#

_____ _____
Client/Legal Representative Signature Date

_____ _____
Provider Representative Date

The Psychology Clinic, Inc.
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(608) 238-9991 FAX (608) 238-1929

The Psychology Clinic, Inc.
1190 Prairie St., Prairie du Sac, WI 53578
(608) 370-6551 FAX (608) 370-6554

The Psychology Clinic, Inc.
137 3rd Ave., Baraboo, WI 53913
(608) 448-2797 FAX (608) 448-2799