Cognitive Behavioral Solutions

Drs. Amy Assemany, Jennifer Holmberg & Kimberly Rubin

CONSENT FOR RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

Patient Name:____________________________________**Birthdate:**_____________________

Address:____

Healthcare is best provided with continuity among service providers. To assist with continuity, I will send a letter to your [your child's] Primary Care Physician informing him or her that you are [your child is] receiving treatment and a brief description of our treatment goals. Please sign the consent form below if you would like Cognitive Behavioral Solutions to release the described information. **The undersigned gives permission for Cognitive Behavioral Solutions to inform the above named patient's Primary Care Physician in writing of our treatment relationship and treatment goals.**

Individual/Agency: ____

Address: ____

____

SIGNATURES: ____

Patient/Guardian

____________________________________ ______________

Relationship **Date**

____

Witness

312 N. Main Street, Plymouth, MI 48170
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