Myrtle C. Means, Ph.D., P.C.

COORDINATION OF CARE

Name: _____ Date of Birth: _____

Address_____

City: _____ State:_____ Zip_____

( ) I **authorize** the release of my treatment information to help coordinate care with my Primary Care Physician.

( ) I **do not authorize** the release of any information to my physician.

Physician's Name: _____

Address: _____

City: _____State: _____Zip: _____

Office Phone: _____Fax: _____

_____

Patient Signature (Parent or Guardian Signature if patient is a minor) Date

_____

Witness Signature Date

//

Staff Use Only

Date Admitted to Treatment: _____ Diagnosis: _____

Type of' Treatment: ( ) Individual ( ) Couples Counseling ( ) Family

Frequency: ( ) Weekly ( ) Bi-weekly ( ) Monthly ( ) Other

Medical Concerns/Medications

_____

_____

_____

Myrtle C. Means, Ph.D. Date

_____