The Psychology Clinic, Inc.

CONSENT FOR RELEASE OF INFORMATION WITH PRIMARY CARE PHYSICIAN

I, _____, _____, **authorize** or **do not authorize**
Client Name DOB (Circle One)
an exchange of information about my treatment at The Psychology Clinic with my primary care physician or provider listed below:

_____ _____
Primary Care Physician Clinic Affiliation

_____ _____
Clinic Address Clinic Phone#/Fax#

_____

_____ _____
Client/Legal Representative Signature Date

_____ _____
Provider Representative Date

The Psychology Clinic, Inc.
310 North Midvale Blvd., Suite 202, Madison, WI 53705
(608) 238-9991 FAX (608) 238-1929

The Psychology Clinic, Inc.
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(608) 448-2797 FAX (608) 448-2799