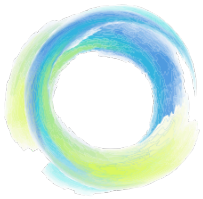

Attune Philadelphia Therapy Group

**AUTHORIZATION TO COMMUNICATE WITH REFERRING HEALTH / MENTAL HEALTH PROVIDER**

It may be beneficial for me to confer with your referring provider with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment.

Please check ONE of the following:

☐ You are authorized to contact my referring provider, whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.

☐ You are authorized to initially contact my referring provider to thank him/her for the referral and/or to let him/her know that you are treating me, but I do not authorize you to discuss the treatment that I am receiving while under your care.

☐ I do not authorize you to contact with my referring provider regarding my treatment with you. I am providing you with the name and address of my provider only for your records.

Name, Address, and Phone Number of Referring Health / Mental Health Provider:

_____

Signature: _____

Name (printed): _____

Date: _____