Malec, Herring and Krause

Licensed Psychologists

195 Crowe Avenue
Mars, PA 16046
724-772-4949
www.MalecHerringandKrause.com

Dear ____________________________
(Patient's Name)

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

____
(Signature of therapist)

Please check one of the following:

____________ Designated therapist is to contact my primary care physician whose name and address are shown below to discuss treatment that I am receiving while under his/her care and to obtain information concerning my medical diagnosis and treatment.

____________ I do not authorize designated therapist to contact my primary care physician with regard to the treatment that I am receiving while under his/her care or to obtain information concerning my medical diagnosis and treatment. I am providing you with the address of my primary care physician only for your records.

Please complete all information below:

Primary care physician: ____

Address: ____

____

____

Phone: ___________________________

Please print your name and address: ____

____

_______________________________________ (Signature of Patient)

________________________ (Date)