Stonebrook
Counseling Associates, PLLC

Primary Care Physician Report

I,_____hereby authorize
Stonebrook Counseling Associates, PLLC, to disclose the following information to:
_____
_____
For the purpose of continuity of care and primary care physician communication.

DIAGNOSIS_____

MEDICATION_____

_____

ATTENDING
PSYCHIATRIST_____

OTHER INFORMATION

_____

_____

This release is null and void following the termination of the therapy or one year from the date of the original release.

_____ _____
Patient Signature/Date Witness Signature/Date

_____
Birth Date

☐ I DO NOT WANT MY PCP NOTIFIED

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