**Patricia M. Wilkins-Vacca, LCSWR**

**504 Haight Avenue**

**Poughkeepsie, NY 12603**

**(845) 527-9456**

**Permission to exchange information with Primary Care Physician**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient, or guardian of patient) do hereby consent to, and authorize Patricia M. Wilkins-Vacca, LCSW (therapist) to share information about diagnosis and treatment plan of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(patient) with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (primary care physician). The purpose of this disclosure is to coordinate treatment with my primary care physician.

I understand that it is my responsibility to share information with my/my child’s primary care physician and therapist regarding any medication that I/my child is currently taking in order to avoid any potential complications.

Any information about my/my child’s treatment will remain confidential.

This authorization is valid for one year unless revoked in writing.

Name of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number of Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client/guardian Date

Signature of therapist Date

\_\_\_\_ Check here if you wish to decline authorization.