Primary Care Physician Notification

Client Name: _____ Date of Birth: _____

This client's Primary Care Physician is as follows:

PCP Name: _____

Mailing Address: _____

City, State, Zip: _____

Phone/Fax: _____

Email address: _____

☐ **I certify I don't have a PCP at this moment**

FOR NOTIFICATION PURPOSES ONLY -- DO NOT SEND RECORDS

Purpose of Release:
This document serves as notification to the Primary Care Physician that counseling and/or behavior analysis services are being provided by Mindful Living of Central Florida, LLC:

Intake date: _____

Clinician Name: _____

Clinician phone: _____

Acknowledgement:

By signing below, I authorize Mindful Living of Central Florida, LLC to release a copy of this document to the PCP named above. I further authorize exchange of confidential information between the PCP and Mindful Living of Central Florida, LLC for the purpose of coordination of care. Contact information for Mindful Living of Central Florida, LLC is as follows:

☐ Email: mindfullivingfl@gmail.com

- I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Mindful Living of Central Florida, LLC
- I understand that I may revoke this authorization in writing at any time; however, I cannot revoke authorization for action that has already been taken.
- A copy of this release shall be valid as the original.

THIS CONSENT EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE SPECIFIED.

_____ _____
Client/Legal Guardian Signature Date