RELEASE OF INFORMATION TO
PRIMARY CARE PHYSCIAN (PCP)

Your PCP is the medical representative responsible for coordination of your total care. Therefore, it is appropriate for him or her to be aware of the behavioral therapy taking place under my care. With your permission, I would like to communicate basic treatment information to your PCP after your initial evaluation. Any further communication will require additional permission.

Please initial the appropriate statement:

Please **DO NOT** contact my PCP after my initial session: _____

Please **DO** contact my PCP after my initial session: _____

My PCP is:_____
Address:_____
City:_____ State:_____ Zip:_____
Phone:_____ Fax: _____

Signature: _____Date: _____

Leslie Caffey, MA,LPC,CCTP
5925 Forest Lane, Suite 415
Dallas, TX 75230
469-994-1075