The attached form is a consent for release of information. Please provide your doctor or primary care clinic's contact information including name of the clinic and phone number. Please also sign the bottom of the form indicating that you consent to release of information for the purposes of coordination of your care. If you do not consent to the sharing of information you may indicate so here.

- I consent to the release of information to my primary care doctor.
- I do NOT consent to the release of information because _______________________________.

____ __________________

Client Signature Date