COORDINATION OF TREAMENT: It is important that all health care

providers work together. As such, I would like your permission to communicate

with your primary care physician and/or psychiatrist. Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that we

have acted in reliance on such authorization. If you prefer to decline consent no

information will be shared.

\_\_\_\_You may inform my physician(s) \_\_\_\_I decline to inform my

Physician

PHYSICIAN

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLINIC:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

CONSENT FOR TREATMENT OF CHILDREN OR ADOLESCENTS: I/We consent that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ maybe treated as a client by Tenecia M Bullock-Funches, LPC. All appointments will be after

hours i.e. 5:00 p.m. or later unless other arrangements have been made. It may

be necessary for the guardian to remain present in waiting area while session is

being conducted. We ask for your cooperation in order that, we provide the

timeliest treatment for you and your children.

Signature(s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_