



Credence Therapy Associates
1 ½ West Geneva Street
Elkhorn, WI 53121
(262)723-3424

Name of Patient _____ Age as of today's date _____

Notification of Primary Care Physician

Please read the following statements and provide your initials or signature where indicated agreeing that you did review this and understand its contents. If you have any questions, please ask your therapist or any of the office staff to assist you. You will also be given a copy of this document upon request

If the patient is age 18 or over, patient initials/signatures only;

If the patient is age 13 to 17, patient and parent initials/signatures;

If patient is age 12 or under, parent initials/signatures only.

(Choose one)

I hereby Authorize ***Patient Initials*** _____ ***Parent Initials*** _____

I hereby Waive ***Patient Initials*** _____ ***Parent Initials*** _____

the requirement that my therapist at Credence Therapy Associates notify my/my child's Primary Care Physician of my treatment and progress.

Patient Signature (Age 13+):

Signature

Date

*Parental/Guardian Signature
(for clients under age 18):*

Signature

Date

Witness Signature:

Signature

Date