Beth Onufrak, Ph.D.
Clinical Child Psychologist
1300 E. Missouri Ave. #230
Phoenix, AZ 85014
(602) 386-1292
DrBethKids.com

COORDINATION of CARE with Primary Care Provider / Other Medical Provider

For Child *(name)*_____ DOB: _____

My child has begun receiving psychological services from Dr. Beth Onufrak.
I authorize my child's physician(s) (below) to communicate with her as needed.

_____ / _____
(Name of professional) (Title: pediatrician, nurse practitioner, etc)

Facility name: _____

Office address: _____

Phone #: _____ Fax #: _____

_____ _____ _____
(Signature of legal guardian) (relationship to child) (today's date)

_____ _____ _____
(Signature of legal guardian) (relationship to child) (today's date)

This consent will remain in effect until : ❑ 90 days (ending on _____) ❑ End of Treatment, or ❑ special event/condition): _____. It may be revoked by the guardian at any time.

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Dear Dr. _____,

*Please feel free to contact Dr. Onufrak anytime by cell **(602) 292-8198**. Or to schedule a phone appointment, your staff may call the office line (602.386.1292, option #3), and her assistant Rhonda will set it up. Thank you for coordination of care about this child!*

Note to party receiving information: This information has been disclosed to you from confidential records which are protected by federal law, prohibiting any further disclosure of this information without the specific written consent of the person to whom it pertains (or that person's legal guardian), or as otherwise permitted by such regulations. If you receive this information in error, please destroy it after contacting the sender at the numb