NICOLE L. HARRIS
MARRIAGE AND FAMILY THERAPIST

Physician Consultation

Effective January 1, 2015

I understand that when I describe symptoms that may be consistent with a mental health disorder, these symptoms can have medical or biological origins, and that my therapist must consult with my physician, unless I waive this requirement.

***Please select, No, I do not want my therapist to contact my physician, if you prefer to waive this requirement.**

No, I do not want my therapist to contact my physician and I waive this requirement.

X_____ Date:_____
Signature of Client/Parent/Guardian

_____ _____
Printed Name Relationship to Client if Minor

X_____ Date:_____
Signature of Client/Parent/Guardian

_____ _____
Printed Name Relationship to Client if Minor

Yes, I request that my therapist consult with my physician regarding my mental health. An additional release form will be required with provider contact information.

X_____ Date:_____
Signature of Client/Parent/Guardian

_____ _____
Printed Name Relationship to Client if Minor

X_____ Date:_____
Signature of Client/Parent/Guardian

_____ _____
Printed Name Relationship to Client if Minor

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