Behavioral Healthcare Services

435 Shrewsbury Street
Worcester, MA 01604
Tel: 508-753-5554
Fax: 508-752-7245

LETTER TO PRIMARY CARE PROVIDER

Date: _____

Address: _____
_____
_____

Fax Number: _____

Dear _____

I am writing to you on behalf of _____
(Print Name and Date of Birth)
to whom we are both providing services. I am sending along a copy of a signed consent to release confidential information form, and a behavioral health provider/ primary care provider communication form which I would like you to fill out and fax back to me at 508-752-7245. I have filled out Section A.

If you have any questions/concerns or would like to discuss our work with this client further please do not hesitate to contact me, I look forward to working with you as we collaborate to provide the best service that we can.

Sincerely,

_____

○Amjad Bahnassi, MD
○Kimberly Abdow, MS, NP-C
○Michael Pizza, APRN/BC