Coordination of Healthcare Services

Please complete the following:

____ I **do not** give permission to communicate with other healthcare providers

____ I **do** give permission to contact the following health care providers (i.e. primary care, psychiatrists, school social workers, etc.)

1. Name_____

Address _____

Phone _____

2. Name_____

Address _____

Phone _____

3. Name_____

Address _____

Phone _____

_____ _____

Signature Date