ERIC B. SPIEGEL, PH. D.

LICENSED PSYCHOLOGIST

AUTHORIZATION TO COMMUNICATE WITH YOUR PRIMARY CARE PHYSICIAN (PCP)

It may be beneficial for me to confer with your primary care physician with regard to your psychological treatment or to discuss any medical problems for which you are receiving treatment.

Please check ONE of the following:

You are authorized to contact my primary care physician, whose name and address are shown below to discuss the treatment that I am receiving while under your care and to obtain information concerning my medical diagnosis and treatment.

You are authorized to initially contact my primary care physician to thank him/her for the referral and/or to let him/her know that you are treating me, but I do not authorize you to discuss the treatment that I am receiving while under your care.

I do not authorize you to contact with my primary care physician regarding my treatment with you. I am providing you with the name and address of my primary care physician only for your records.

Name, Address, and Phone Number of PCP:

____

Signature: ____

Name (printed): ____

Date: ____

132 SOUTH 17TH STREET, PHILADELPHIA, PA 19103

WWW.ERICSPIEGELPHD.COM TEL: (215) 222-4825 ESPIEGELPHD@GMAIL.COM