Mindful Living PLLC
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Coordination of Care Consent Form

_____ I agree to have my therapist _____ of Mindful Living contact my primary care physician.

_____ I do not agree to have my therapist _____ of Mindful Living contact my primary care physician.

If I agree my primary care physician's contact information is:

Name: _____

Practice (if different): _____

Address: _____

Phone: _____

FAX: _____

Client Signature _____ Date _____

Witness Signature _____ Date _____