1032 Turnpike Street
Suite 204
Canton, MA 02021

Renz Counseling

378 Page Street
Suite 6
Stoughton, MA 02038

Primary Care Physician Contact Information & Consent Form

Patient name: _____

Date of Birth: _____

Date of first appointment: _____

Primary Care Physician Info	
Name:	
Address:	
Phone #:	

Therapist name: _____

Therapist phone #: _____

I hereby give permission for Renz Counseling to contact my Primary Care Physician to discuss my health care, should they feel it would benefit my treatment.

Patient signature: _____

Patient name:
(please PRINT) _____

Date: _____