## MEDICAL

Current Medical Conditions, including allergies: _____
_____
_____
_____
Current Medications (indicate dosages): _____
_____
_____
_____
_____

## Consent to Release Information to Your Prescribing Physician

If you take psychiatric medication or suffer from a stress-related illness, treatment is more effective if the health care providers treating you coordinate their efforts. **If you would like me to coordinate with your prescribing physician, please complete the release of information below.**

I, _____, _____ authorize
(please print name) (date of birth)
Dawn Taylor, Ph.D. to release information related to my evaluation and treatment to my prescribing physician. Information to be released ( ) does ( ) does not include information about substance use. I understand that I may revoke this consent at any time.

_____ _____
Signature Date

_____ _____
Parent/Guardian Signature Date

Prescribing Physician: _____
Address (with zip code): _____
_____
_____
Telephone: _____