Jan Stone, MA, LPCC, NCC
A Mindfulness Approach to Individual and Couples Counseling and Psychotherapy
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(505) 610-9214 FAX: (505) 298-3939

Medical Information

Name: _____ Date of Birth: _____

Do you have any medical diseases or problems that you feel are affecting your mental health?

(Circle one) Yes No

If yes, please explain:

_____
_____
_____
_____
_____
_____

Unless you authorize coordination of care with your medical doctor, we will not automatically send your doctor information about your treatment here, including diagnosis and records related to emotional/mental/developmental disabilities/psychiatric conditions and treatment plan.

If you do want your psychological diagnosis and counseling information shared with your medical doctor, your doctor's name, address or fax number are required in order to coordinate care.

Please indicate below your preference (choose one):

_____ I do not wish to have my diagnosis and records related to emotional/mental/developmental disabilities/psychiatric conditions and treatment plan shared with my medical doctor.

_____ I want my behavioral health information shared with my medical doctor, including records related to emotional/mental/developmental disabilities/psychiatric conditions and treatment plan. I understand that I must provide contact name, address, phone and fax number of my doctor. My doctor's information is as follows:

Doctor's Name: _____

Address: _____

Doctor's Phone Number: _____Doctor's Fax Number: _____

Please sign and date regardless of the option that you choose:

Your signature: _____ **Today's Date:** _____