Crossroads Counseling Center, Inc.
Winchester Outpatient Clinic
420 W. Jubal Early Drive, Suite 203
Winchester, VA 22601
Phone: 540-773-3193; Fax: 540-773-4982

PCP Consent Withheld/No Current PCP Acknowledgement

Client Name: _____ Date: _____

Parent/Authorized Representative Name (if required): _____

☐ I, _____, hereby decline to provide consent to Crossroads Counseling Center, Inc. (CCC) to release or exchange my/my child's substance use disorder information with my/my child's Primary Care Physician/Pediatrician.

☐ I/my child do/does not currently have a Primary Care Physician/Pediatrician. I agree to notify Crossroads Counseling Center, Inc. when I/my child obtains a Primary Care Physician/Pediatrician.

_____

Client or Parent/Authorized Representative signature Date

_____

Witness signature Date