

PCP NOTIFICATION OF TREATMENT LETTER

Provider's Name: Robert L. Feder, LCSW
Provider's Address: 6436 S. Quebec Street, Suite 100
Englewood, Colorado 80111
Provider's Phone No.: (720) 488-3168
Provider's Fax: (720) 488-1852

Date

To: _____

Dear Dr. _____

Re: _____

I.D.#: _____

This letter is to inform you that I am providing professional mental health services for the above named patient and I have received authorization to inform you of this. If you desire additional information about this case, please contact me at the phone number listed above. Please also note the following:

_____ No information is requested from your office at this time

_____ Information is requested as listed on the authorization for release of information form, which is included.

Sincerely,

Robert L. Feder, LCSW