



# Gilead Behavioral Health

*Helping People. Healing Communities.*

132 East 79<sup>th</sup> Street Chicago, IL 60619 | Phone: 773-487-0515 | Fax: 773-487-0525

Date: \_\_\_\_\_

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State and Zip code

Re: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dear Dr.: \_\_\_\_\_

This letter is to notify you that the above named patient is currently under my care for behavioral health concerns. It is our desire to become a part of the patient's total healthcare program. Gilead Behavioral Health, Inc. has been authorized to share information related to the patient's treatment with his/her Primary Care Physician and/or other Health Care Provider(s). A signed copy of the patient's Informed Consent and Release of Information is on file in our office.

If you have any questions or if we can be of assistance, please feel free to contact our office.

Sincerely:

Dr. Karen Y. Douglass, Psy.D

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date