Date:

Clinician’s Full Name:

License/Medical Practice No.:

Patient’s Full Name:

Date of Birth:

The above-named individual is currently receiving services at this program, which is a program licensed, operated, certified, or funded by the NY State Office of Mental Health. This letter is being issued at the patient’s request and is intended solely to confirm their enrollment and treatment in this program.

This letter contains protected health information which must be kept confidential and cannot be further disclosed without patient authorization or as allowed by state and federal privacy laws.

Should you require any further information, please do not hesitate to contact our office.

Sincerely,

Clinician’s Signature

Date