NOTIFICATION TO PATIENT
OF DESIRABILITY OF CONFERRING WITH PRIMARY CARE PHYSICIAN

Pursuant to Illinois Law, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one. If you have a primary physician, I am required to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

Please let me know what you would like me to do by checking the appropriate line below:

_____ **Do notify my primary physician.**
I agree to you notifying my primary care physician that I am seeking or receiving mental health services. I am signing the attached Authorization of Release Information permitting you to communicate with my said physician.

_____ **DO NOT notify my primary care physician.**
I waive notification of my primary care physician that I am seeking or receiving mental health services, and I direct you NOT to notify him/her.

_____ I do not have a primary care physician and do not wish to confer with one. Therefore, I waive notification of a primary care physician that I am seeking or receiving mental health services.

_________________ ____

Date Patient (12 YEARS OR OLDER)

_________________ ____

Date Parent or guardian of minor patient or ward

NOTIFICATION TO PRIMARY CARE PHYSICIAN
OF PATIENT RECEIVING MENTAL HEALTH SERVICES

Pursuant to Illinois law requiring that Licensed Mental Health Workers inform their patient's primary care physicians that a patient is seeking or receiving mental health services, you are hereby notified that ____is seeking or receiving such services form me. The patient and/or their parent or guardian has singed an Authorization for Release of Information, a copy of which I am enclosing for your records. I look forward to the opportunity to confer with you about this patient as the occasion or need arises. **This is not a request for records to be sent to us.**

_________________ ____

Date Therapist Name