SAMARITAN COUNSELING CENTER OF THE NORTHWEST SUBURBS

NOTIFICATION TO CLIENT OF DESIRABILITY OF CONFERING WITH PRIMARY CARE PHYSICIAN

If you have a primary care physician we would welcome the opportunity to notify him or her that you are seeking or receiving mental health treatment unless you waive such notification.

PLEASE INDICATE YOUR WISHES

PRIMARY PHYSICIAN:____

ADDRESS:____

____

PHONE: ______________________

FAX:________________________

❑ I agree to your notifying my Primary Care Physician that I am seeking or receiving mental health services. I am signing this authorization permitting you to communicate with my said 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 see or confer with one. I therefore, waive notification of a Primary Care Physician that I am seeking or receiving mental health services.

Signature: ____________________________________ Date: ________________
(12 and over)

Signature:_____________________________________Date: ________________
(Parent or Guardian)