**Notification 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 indicate your wishes:

\_\_\_\_My primary physician is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_I agree to your notifying my primary care physician that I am seeking or receiving mental health services. I am signing the Authorization of Release Information 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 so notify him or 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Client

Notification to Primary Physician of Patient Receiving Mental Health Services

Pursuant to Illinois law requiring that Licensed Clinical Professional Counselors inform their patients’ primary care physicians that a patient is seeking or receiving mental health services, you are hereby notified that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is seeking or receiving such services from me. The patient has signed an Authorization for Release of Information, a copy of which I am enclosing for your record. I look forward to the opportunity to confer with you about this patient as the occasion or need arises.