Counseling Center For Emotional Growth
5225 Old Orchard Road
Suite 29
Skokie, Illinois 60077
Phone 847-967-0952 -Fax 773-248-5324

PHYSICIAN NOTIFICATION OF SERVICES AND CONSENT TO RELEASE INFORMATION

NOTIFICATION TO CLIENT

Pursuant to Illinois Law PL 86-1434, you are herby informed that it is desirable that you confer with your primary physician, if you have one, about seeking and receiving mental health services.
Please indicate your desire by checking the appropriate box:

____ I do not have a primary care physician and do not not wish to see or confer with one. I therefore waive notification of a 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 my primary care physician.

____ I agree to your notifying my primary care physician that I am seeking or receiving mental health services.

My primary care physician is:

Physician Name:______________________________

Address:______________________________City:______________________State_____Zip______

Telephone:____________________

Client Name:______________________________ Date:________________

Client Signature:______________________________