NOTIFICATION TO CLIENT OF RECCOMENDATION TO INFORM PRIMARY CARE PHYSICIAN OF MENTAL HEALTH SERVICES (FOR CLIENTS WITH INSURANCE):

I, (client, parent, guardian) _____ have been informed, pursuant to Illinois law that is desirable that I discuss with my primary care physician, if I have one, about seeking or receiving mental health services. Unless I waive notification to my primary care physician, Illinois law requires that my physician be notified that I am receiving mental health services. I have been informed that I have the right to waive notification to my primary care physician.

☐ I have indicated my choice by checking off one of the following boxes:

☐ I do not have a primary care physician;
And I do not wish to confer with one. I therefore WAIVE NOTIFICATION to a primary care physician that I am receiving mental health services.

☐ I do have a primary care physician;
However, I do not want him or her to be called. I WAIVE notification to my primary care physician that I am seeking or receiving mental health services, and I direct that you NOT notify him/her.

Please contact my primary care physician.
I AGREE to your notifying my physician that I am seeking or receiving mental health services. My signature below is a Release of information permitting you to notify my physician of this fact. (Release of any content of treatment requires a separate Release is signed specifying the information to be released.) My primary care physician is:

NAME_____

ADDRESS _____

Signature of client _____ Address_____ Date_____

Signature of Parent/Guardian (If client is under 18) _____
Address_____ Date_____

A SEPARATE RELEASE OF INFORMATION MUST BE SIGNED IF ANY CONTENT OF TREATMENT IS TO BE RELEASED, OR IF ANY ONGOING COMMUNICATION IS TO OCCUR WITH THE PRIMARY CARE PHYSICIAN.

A COPY OF THIS FORM MUST BE RETAINED IN THE RECORD FOR AT LEAST 5 YEARS FROM THE DATE SIGNED.