

**Notification to Patient of Desirability of Confering with
Primary Care Physician**

Date: _____

Patient First Name Patient Middle Initial Patient Last Name

Street Address Apartment or Unit Number City State Zip

Date of Birth: _____ Telephone Number: _____

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 care physician, North Shore Senior Center is required to notify that person that you are seeking or receiving mental health treatment, unless you waive such notification.

Please indicate your wishes:

- I agree to North Shore Senior Center notifying my primary care physician that I am seeking or receiving mental health services. I am signing this form and an Authorization to Release Information form permitting North Shore Senior Center to communicate with the physician identified on the release:
Physician Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____
- I **WAIVE NOTIFICATION** to the primary care physician that I am seeking or receiving mental health services, and I direct North Shore Senior Center **NOT** to notify the physician.
- I do not have a primary care physician and do not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** of the primary care physician that I am seeking or receiving mental health services.

Signature of Patient

Date

North Shore Senior Center Staff Signature/Title

Date

**Notification to Primary Care Physician of Patient Receiving
Mental Health Services**

Pursuant to Illinois law requiring that Licensed Clinical Social Workers inform their patients' primary care physician that a patient is seeking or receiving mental health services, you are hereby notified that

Patient First Name Patient Middle Initial Patient Last Name

Is seeking or receiving services from North Shore Senior Center. The patient has signed 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 arise.

North Shore Senior Center Staff Signature/Title

Date