3467 Orchard Lake Rd.
Keego Harbor, MI 48320
(248)722-2653

PRIMARY CARE PHYSICIAN NOTIFICATION FORM

Name of Patient_____

Name of Parent/Legal Guardian (if necessary)_____

Name of Physiian_____

Address_____

CONSENT TO EXCHANGE INFORMATION

I, _____agree to release my, or my son's/daughter's medical records to the above-named physician. I understand the purpose of, and agree to, providing this information to assist my physician in coordinating the necessary care between my behavioral health care provider and my primary care physician. I understand that such information may include my primary diagnosis associated symptomology, and treatment recommendations.

_____

Patient/Parent/Legal Guardian Signature Date

_____

Clinician/Witness Signature Date

_____(initials) I do not wish to exchange information with my primary care physician. I understand that I take full responsibility to communicate to my primary care physician my diagnosis and treatment recommendations offered to me by Full Circle Behavioral Health.

This consent will remain active until it is revoked in writing or until the case is closed.