M.D. RELEASE FORM

Direction: Please complete the following information in order for this letter to be faxed or mailed to your primary care physician. You may choose not to send this letter by checking one of the boxes and signing the bottom of the page.

Name of Physician: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
Name of Clients: _____

JEAN MILLER COUNSELING CENTER OFFICE USE ONLY	
DATE FAXED	**FAXED BY INITIALS**

Dear Physician,

I have been advised by my counselor that it is my best interest to advised my primary care physician of my counseling services at Jean Miller Counseling Center LLC (JMCC) in Bolingbrook, IL. I also consent to my counselor release this information. Please place this letter in my file as notification that I currently receiving counseling services. If you would like information about the initial evaluation (including information gathered in the first three sessions only), you may contact my counselor at the number above.

I understand that I may change the choice I have made at any time upon written notification to JMCC, and will hold JMCC blameless for any information previously withheld or provided to my physician before my change of consent. I also acknowledge that this consent will be in effect for 90 days following my last visit to the Center.

_____
Signature of Client or Responsible Party Date

_____
Signature of JMCC Counselor Date

I have read the above letter, and choose not to have my counselor contact my physician at this time.
Instead, I elect to:

☐ Inform my physician myself.

☐ Waive information my physician at this time.

_____
Signature of Client or Responsible Party Date

_____
Signature of JMCC Counselor Date

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