THE GUIDANCE CENTER
ADULT AND FAMILY SERVICES, INC.
19291 NORTHLINE ROAD
SOUTHGATE, MI 48195
PHONE:(734)-287-1500 FAX: (734)-287-1660

PRIMARY CARE PHYSICIAN NOTIFICATION RELEASE

Name of Patient____

Name of Parent/Legal Guardian (if necessary)____

Name of Physician____

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 diagnosis and the current medications I, or my son/daughter, am/are taking.

I understand that my signature means that any change in medication during the course of my, or my son/daughter's treatment at The Guidance Center, Adult and Family Services, will result in the communication with my primary care physician the specific medication and dosage.

____ ____________
Member/Parent/Legal Guardian Signature **Date**

____ ____________
Witness Signature **Date**

(Optional)_______(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, treatment, and any medications that I have been prescribed by The Guidance Center, Adult and Family Services, Inc.

Reason(s) for not agreeing to exchange info: ☐**Doesn't need to know** ☐**Personal**
☐**Other**__________________________________

FOR OFFICE USE ONLY
THERAPIST NAME/CREDENTIALS____

PSYCHIATRIST NAME/CREDENTIALS____

PRIMARY DIAGNOSIS_______________________________________ CODE_____________

MEDICATIONS PRESCRIBED:____

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DATES SENT TO PCP:________, ___________, ___________, __________, __________