Behavioral Health Providers, P.C.

Helping you through life's transitions

We will only use and disclose the following information for health information about you for treatment, payment, and healthcare operations. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Please complete the following - All Information is required

PRIMARY CARE PHYSICIAN NOTIFICATPION OF CLINICAL SERVICES
AND CONSENT FOR THE RELEASE OF INFORMATION

Pursuant to Illinois Law PL 86-1434, you are hereby informed that it is desirable that you confer with your primary physician, if you have one, about seeking and receiving mental health services. Unless you waive such notification, Behavioral Health Providers, P.C. is required to notify your primary physician that you are seeking or receiving mental health services.

Dear Dr. _____ _____
(Primary Care Physician First Name) (Primary Care Physician Last Name)

Address:			
Phone Number:		Fax Number:	
Email:		Website:	

I, _____ am sending this form to notify you that I am currently
(Therapist)

seeing your patient in a therapeutic setting and to provide our offices with a release of information to facilitate communication and to coordinate services in regards to client care. If further information is desired, please contact me at your convenience.

I, _____ _____ of
(Your Name) (Your Date of Birth)

Address:	

1100 Cougar Trail, Cary IL 60013 | Phone: 847-516-2538 | Fax: 847-516-2510
321 Franklin St, Geneva IL 60134 | Phone: 888-291-2538 | Fax: 847-516-2510
Email: b.h.p@comcast.net | http://bhproviders.com

I understand that my records are protected under the Federal and specific State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g., the provision of treatment upon consent to disclose third party payers) and that this consent expires automatically as described below. Information to be released includes diagnosis, treatment procedures and details of my condition which help to coordinate treatment.

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will. This release is valid for 90 days after last contact and I may cancel it in writing at any time.

Signature: _____ Date: _____

☐ I do NOT want my physician to be notified or informed of my treatment.

Signature: _____ Date: _____

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