In-Home Counseling
counseling in the comfort of your own home

800 Main Street, Ste. 210, Antioch, IL 60002
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www.inhomecounselingservices.com

PATIENT_____

DOB_____

I understand that the State of Illinois requires my primary care physician to be notified that I am seeking assistance from In-Home Counseling. I further understand that I may choose to have my therapist NOT notify my primary care physician.

My primary care physician: _____

_____

I choose to have _____notify my physician:

Yes _____ No _____

_____
Signature of Client Date

_____
Witness 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 _____ is seeking or receiving such services from me. 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 arises.

_____
Therapist Date