

**HERITAGE COUNSELING CENTER, INC.**  
24020 W. Riverwalk Ct. Suite 100  
Plainfield, IL 60544  
Phone: 815.577.8970  
Fax: 815.577.8988

**M.D. RELEASE FORM**

Directions: 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 Client: \_\_\_\_\_

Dear Physician,

I have been advised by my counselor that it is in my best interest to advise my primary care physician of my counseling services at Heritage Counseling Center, Inc. (HCC) in Plainfield, IL. I also consent to my counselor releasing this information. Please place this letter in my file as notification that I am 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 HCC, and will hold HCC 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 HCC 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 informing my physician at this time.

\_\_\_\_\_  
Signature of Client or Responsible Party Date

\_\_\_\_\_  
Signature of HCC Counselor Date