Animal Assisted Counseling of Indiana, LLC
900 Ridge Rd, Suite T, Munster IN, 46321
708-730-2600

Consent to release information to Primary Care Physician

Communication between your therapist and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication, if necessary. You may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on (1) year from the date of signature, unless another date is specified.

____ ________________ _________________________

Patient Name Date of Birth Patient Social Security #

Please check one:

☐ I agree to allow my Animal Assisted Counseling of Indiana therapist to release mental health/substance abuse information to my Primary Care Physician.

☐ I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: ____

Physician Address: ____

City, State, Zip: ____

Physician Phone: _______________________________ Fax: ________________________________

____ ____________________________

Patient Signature Date

____ ____________________________

Parent/Guardian Signature Date

Information for PCP:

This patient was seen by me on (date) ___________________ for diagnosis__________________

____ ________________________

Provider Signature Date

____

Provider Printed Name