

**NOTICE OF OBLIGATION TO INFORM  
PRIMARY CARE PHYSICIAN OF SOCIAL WORK SERVICES**

Pursuant to Illinois law, you are hereby informed that it is desirable that you confer with your primary care physician, if you have one, about seeking treatment with a Licensed Clinical Social Worker. I am required to notify him/her that you are seeking or receiving mental health treatment unless you waive such notification.

Please indicate your wishes:

\_\_\_\_\_ I waive notification of my primary care physician that I am seeking or receiving mental health services and I direct you **NOT** to so notify him/her.

\_\_\_\_\_ I do not have a primary care physician and do not wish to see or confer with one. I therefore **WAIVE NOTIFICATION** that I am seeking mental health services.

Date: \_\_\_\_\_ Recipient \_\_\_\_\_

Date: \_\_\_\_\_ Witness \_\_\_\_\_

**OR**

**AUTHORIZATION OF NOTICE  
AND RELEASE OF INFORMATION**

I do not waive notice to my primary care physician. I hereby authorize my Licensed Clinical Social Worker, \_\_\_\_\_, to notify my primary care physician, Dr. \_\_\_\_\_, of \_\_\_\_\_ That I am receiving social work services. This authorization will be effective for \_\_\_\_\_ months (not exceeding 12 months) from the date below. I recognize that the consequences of my refusal to sign this authorization is that I will be asked to sign the above waiver, if I did not do so initially.

Date: \_\_\_\_\_ Recipient \_\_\_\_\_  
(Parent or guardian of recipient, if recipient is a minor or under guardianship.)

Date: \_\_\_\_\_ Witness \_\_\_\_\_

Copies of this document shall have the same force and effect as the original.

NOTE: A copy of this form must be retained by the Licensed Clinical Social Worker for at least five years from the date of completion. Also note that a separate release must be signed to authorize ongoing communication with the primary care physician.