Lake Orion Counseling Center, LLC

3604 Clarkston Road

Clarkston, MI 48346

AUTHORIZATION TO RELEASE PATIENT INFORMATION to Primary Care Physician

I, _____ hereby authorize Lake Orion Counseling Center to notify my medical doctor of my receiving treatment here, along with my diagnosis and other pertinent information.

My medical doctor's name and address are as follows:

Doctor's Name: _____

Street Address: _____

City, State and Zip Code: _____

Phone: _____ Fax: _____

** I realize that a copy of the form letter that will be sent to my physician is available to me upon request. I can rescind this authorization at any time. This authorization will automatically terminate six months after my treatment ends.

Signature of Patient _____ Date _____

_____

Signature of Parent/Guardian (for a minor) Date

_____

Witness Date

Dx Code(s): _____ _____ _____