Lake Orion Counseling Center, LLC

3605 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 _____________

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Signature of Parent/Guardian (for a minor) Date

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Witness Date

Dx Code(s): _______________ _______________ _______________