LATRESA L. WILLIAMS, BSW, ACSW, LMSW
Licensed Clinical Therapist
31584 Schoolcraft Road
Livonia, Michigan 48150
Phone: 248.491.8417 Fax: 313.278.3690

Patient's Name: ____

Name of parent/Legal Guardian: ______________________________________

Name of Physician: ____

Address: ____

CITY: ______________________ STATE: MICHIGAN ZIP CODE: ____________

CONSENT TO EXCHANGE INFORMATION

I, ______________________, agree to release my, or my son's, daughter's medical records to the above-named physician. I understand the purpose of, and agree to, providing this information to assist my physician in coordinating the necessary care between my behavioral health care provider and my primary care physician. I understand that such information may include my diagnosis and the current medications, I or my son/daughter, am/are taking.

I understand that my signature means that any change in treatment during the course of my, or my son, my daughter's treatment at Assurance Counseling, LLC, will result in the communication with my primary care physician the specific treatment if deemed necessary.

______________________________________ ____________________

Client/Parent/Legal Guardian Signature Date

______________________________________ ____________________

Witness Signature Date

(Optional): __________ (Initials) I do not wish to exchange information with my primary care physician. I understand that I take full responsibility to communicate to my primary care physician my diagnosis, treatment by Assurance Counseling, LLC

Reasons(s) for not agreeing to exchange info: ☐ Doesn't need to know ☐ Personal

☐ **Other** ____

FOR OFFICE USE ONLY:

THERAPIST NAME/CREDENTIALS: ______________________________________

PRIMARY DIAGNOSIS: ____________________ CODE: ____________________

DATE SENT TO PCP: ____