



Wellness Counseling

Main Office

One Heritage Place, Suite 261
Southgate, Michigan, 48195

32290 Five Mile Road, Suite 1
Livonia, Michigan, 48154

(734) 778-0663 Fax (734) 785-8328

PCP Release

Patient Name: _____

Patient DOB: _____

Date: _____

Name of Primary Care Doctor: _____

Address of Primary Care Doctors office:

Consent to exchange information with Primary Care Doctor's office.

_____ **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 (Wellness Counseling) 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 do NOT agree**, to share information with my Doctor. I understand that I take full responsibility to communicate to my Primary Care Doctor.

Printed Name: _____

Signature: _____

Date: _____