Lutheran Family Service
For Nothing is Impossible with God

Primary Care Physician Communication Consent

My primary care physician is: _____

Address: _____ Phone: (____) _____ - _____

I hereby authorize my LFS counselor to:

- ☐ Release any applicable mental health information to my doctor named above.
- ☐ Release any applicable substance abuse information to my doctor named above.
- ☐ Release only medical information to my doctor named above.
- ☐ Release NO information to my doctor named above.

I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke this authorization, it will expire one year after I have terminated treatment with Lutheran Family Service.

_____ _____
Signature of Client (or Parent or Legal guardian) Date

Medication Education Review

Please review and select one of the following statements:

- ☐ I am not taking any prescription medications at this time.
- ☐ The doctor/other health care provider who has prescribed medication(s) for me has educated me regarding the reason I am taking the medication(s), the benefits I should see and the potential side effects of taking them. I have also been informed of the possible side effects of the medication should I become pregnant.
- ☐ I need more information about the medication(s) I am taking and their possible side effects.

_____ _____
Signature of Client (or Parent or Legal Guardian) Date

Client Name: _____ Birth Date: _____

Person signing the form is:

- ☐ Client/self
- ☐ Parent (print parent's name): _____
- ☐ Legal Guardian (print guardian's name): _____