MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC

I. Consent To Treat

I hereby certify that MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC clinician Stanley Makrinos MA, PCC-s providing services has informed me of his professional qualifications, certifications, and/or licensure; has provided both an explanation and a copy of client's rights and responsibilities; and has informed me of his assessment, diagnosis, and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended by the undersigned clinician and that information concerning my treatment may be shared with other MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC clinicians should it be deemed useful to my treatment.

_____	_____	_____	_____
Client Signature	Date	Clinician Signature	Date
_____	_____	_____	_____
Parent/Guardian Signature	Date	Supervisor Signature (if applicable)	Date

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II. Consent To Release Patient Information To Primary Care Physician and Coordinate Care

◯ **I authorize MAKRINOS MENTAL HEALTH COUNSELING SERVICES, LLC to contact my primary physician:**

_____, M.D.

_____
(Phone Number)

_____
(Street Address)

_____
(City, State Zip)

To provide information regarding my treatment, diagnosis, behavioral, mental and emotional functioning, and behavioral health status.

◯ **I do not wish my primary care provider to be contacted at this time.**

_____	_____	_____	_____
Client Signature	Date	Clinician Signature	Date
_____	_____	_____	_____
Parent/Guardian Signature	Date	Supervisor Signature (if applicable)	Date