Maggie Alexander, PMHNP, LLC **Psychiatric Mental Health Nurse Practitioner**

3095 SW 118th Ave Beaverton, OR 97005. Telephone: 503. 522.9629 Fax: 503.992.6625

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER

I,_____, hereby authorize Maggie Alexander, PMHNP to receive information from and/or send information to the clinician indicated below. This release pertains to the following types of information: medical history, mental or physical conditions or treatment, including information relating to my mental health diagnosis and/or substance abuse diagnosis and treatment to my primary care provider.

Clinician Name: _____

Clinician Address (Street, City, and Zip): _____

Clinician Phone Number and/or Fax Number: _____

This authorization for release extends to the care and treatment the client received during:

□ All dates of service or

□ Service between_____and _____

This information may be used for the following purpose(s):

□ Evaluation, assessment and/or treatment and/or □ Ongoing coordination of treatment and/or

□ Other: _____

The information to be released is:

□ Diagnoses □ Psychological Evaluations/Reports □ Medical Evaluations

□ Treatment Plan or summary □ Chemical Dependency Information □ Other: _____

□ This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire:

□ One year from date signed or □ Upon termination of treatment or □ Other:_____

_____ _____

Signature of client, parent, or legal guardian Date signed

_____ _____

Witness Date signed

FOR Maggie Alexander, PMHNP TO COMPLETE:

Primary Care Provider: _____

The purpose of this letter is to notify you that your patient_____, (DOB:_____)

has begun mental health services with me. I believe it is important to coordinate mental health medical services with the medical care, which you are providing. I will be contact in you as needed to discuss any concerns or questions that I have regarding the mental health issues. To the above address or fax number, please send any information that you deem important to the mental health services being provided or call. Thank you. DSM-IV Diagnosis:

Axis I:_____

Axis II:_____

Known Current Psychotropic Medications: □ None

_____

_____

Medical Condition/s: _____

Treatment (Therapy) Modalities: □ Individual □ Family □ Couples □ Group □ Other:

Estimated Length of Treatment: □ 3 months □ 6 months □ 9 months □ Other:

Please help monitor these risks: □ None □ Suicidal Ideation □ Homicidal Ideation □ Poor self-care

Coordination of Care Issues: _____

_____

_____ _____

Maggie Alexander PMHNP-BC **Date**