Primary Care Provider Information
Behavioral Health Associates

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Suite 301
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Phone 206 218 7432

(To be completed by patient)

Patient Name:_____ **Date of Birth**_____

Patient's Physician_____ **Physician's Phone**_____

I hereby give my consent for exchange of information with my physician:

Patient signature_____

Date: _____

(To be completed by clinician)

Reason for communication:

____ Provide initial evaluation information

____ Inform that patient is receiving mental health services

____ Suggest consideration of medication

____ Provide information re: medication effects/ progress update/ change in status

Diagnosis:

Risk Factors:

Comments / Treatment Plan: _____

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