Primary Care Provider Information
Behavioral Health Associates

Julie Behrens, PsyD
2200 24th Ave. E.
Seattle, WA 98112
Phone 206-920-8927
Fax 206-328-2310

(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: ____

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