Catherine Samson, PMHNP, LLC ***Psychiatric Mental Health Nurse Practitioner***

516 SE Morrison, Suite 705 Portland, OR 97214

Telephone: 503.679.6470
Fax: 503.296.2996

FOR PATIENT TO COMPLETE:

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER

I, ______________________________, hereby authorize Catherine Samson 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

☐ On going 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 CATHERINE SAMSON, PMHNP-BC 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

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

___________________ ___________________ ___________________ ___________________

Reported Medical Conditions: ____

Treatment (Therapy) Modalities: ☐ Individual ☐ Family ☐ Couples ☐ Group ☐ Other: __________

Estimated Length of Treatment: ☐ 2 months ☐ 4 months ☐ 6 months ☐ Other: ________

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

Coordination of Care Issues:

____

____

____

________________________________ _____________________

Catherine Samson, MS, MPH, PMHNP-BC Date Completed