HAMPTON MENTAL HEALTH ASSOCIATES
2208 EXCECUTIVE DR • STE A-E • HAMPTON • VA • 23666
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Consent to Exchange Confidential Information with PCP

Patient Name: _____ Date of Birth: _____/_____/_____

Patient's Address: _____ City: _____ State _____ Zip _____

Primary Care Physician: _____ **PCP Phone #_____**

EXCHANGE INFO WITH PCP: YES or NO ***(please circle one)***

Patient (Guardian) Signature_____ Date: _____

Signature of Witness Signature _____ Date: _____

Initial Summary (for all Providers) Date of Initial Visit: _____

Presenting Problems: _____

_____

Diagnosis (DSM- IV)

Axis I _____ _____ Axis IV_____
Axis II _____ _____ Axis V (Current)_____
Axis III_____ Axis V (Past)_____

Treatment Plan/Recommendations:

1)_____

2)_____

3)_____

4)_____

Comments for PCP: _____

_____

Provider Signature: _____ Provider #: _____

Provider Name: _____ Date: _____

Revised 05/15