



Release of Information and Guidelines for Medication Consultation with Dr. Lynn Shell

I, _____, give Dr. Lynn Shell and my PTS or off-campus therapist permission to confer about my mental and physical health, including information about substance use, medications and complementary treatments.

I understand that:

1. This will help with a referral, evaluation, consultation, and/or collaboration for treatment planning;
2. In order to protect the limited confidentiality of my records, my agreement to obtain or release information is necessary and that this permission is limited to the purpose and parties listed above;
3. What I share with my therapist is confidential; I may share whatever I wish to with PTS staff as well;
4. I may withdraw this permission at any time by written request except to the extent that action has already been taken;
5. I will pursue regular counseling with a therapist while engaged in medication management with Dr. Shell (at the frequency recommended by both providers);
6. I will follow the plan for supplements or medications as agreed and make no changes without prior discussion with Dr. Shell and my therapist;
7. It is my responsibility to see that I do not run out of a medication, especially if I have missed a scheduled appointment with Dr. Shell. If I will need a new prescription before my next appointment, I will contact the counseling office at 609-497-7844 or email Christy.hunterprice@ptsem.edu with at least three days' notice. At that time, I will provide my birthdate, and the name and dose of the medication I am taking, along with the name and phone number of my pharmacy;
8. In a psychological crisis, I will contact my therapist, go to an Emergency Room or follow the PTS guidelines on the Student Counseling website;
9. A copy of this authorization is the same as the original. This authorization expires on _____.

(Student/Spouse Signature)

(Date)

(Dr. Lynn Shell, PhD, APN)

(Date)

Therapist's Name: _____

Phone: _____

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