

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in six (6) months from the date of my signature below unless otherwise stated herein.**

_____ is authorized to release protected health information related to the evaluation and
(Provider Name-Please Print)
treatment of _____ / _____ / _____.
(Member Name) (Member ID#) (Date of Birth – MM/DD/YYYY)

PCP Name: _____ PCP Phone: _____

PCP Address: _____
(Street) (City) (State) (Zip Code)

BH Provider Name: _____ BH Provider Phone: _____

BH Provider Address: _____
(Street) (City) (State) (Zip Code)

Other Name: _____ Other Phone: _____

Other Address: _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply)

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Face sheet | <input type="checkbox"/> History & physical | <input type="checkbox"/> Laboratory/diagnostic testing results | <input type="checkbox"/> School information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Medication records | <input type="checkbox"/> Behavioral health/psychological consult | <input type="checkbox"/> Psychological eval/testing results |
| <input type="checkbox"/> ER record report | <input type="checkbox"/> Psychiatric evaluation | <input type="checkbox"/> Psychosocial assessment | <input type="checkbox"/> Other |
| <input type="checkbox"/> Substance abuse treatment record | <input type="checkbox"/> Summary of treatment records & contact dates | | |

I hereby refuse to give authorization for any release of information

(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)
If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)