This form is provided as a sample. It is not being provided to fit a particular set of circumstances, nor is it to be used as a clinical assessment tool. You have the sole responsibility for ensuring that the release of information follows all state and federal requirements and is in accordance with applicable standards of practice for your license/specialty.

Coordination of Care Between Health Care Providers and Release of Information

Communication between behavioral health (BH) care providers and your primary care physician (PCP), and other behavioral health providers and/or facilities, is important to ensure you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. 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 already may have been used or disclosed based on your previous permission.
- 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 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 number) (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)

___ Face sheet	___ History and physical	___ Laboratory/diagnostic testing results	___ School information
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological evaluation/testing results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Other
___ Substance abuse treatment record		___ Summary of treatment records and 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, guardianship papers, etc.)

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Coordination of Care Between Health Care Providers and Release of Information

I want to inform you that _____ was seen by me for the treatment of:
(Member name)

DSM-5, ICD-10 and/or medical diagnosis:_____

Date of appointment: _____

Summary: _____

_____

_____

_____

The treatment plan consists of the following modalities:

___ Individual psychotherapy ___ Group psychotherapy ___ Family psychotherapy

___ Psychological testing ___ Other (specify) ___ Medication management (see below)

Current medication(s) (dosage, frequency and delivery)

_____

_____

_____

_____

_____

The following medication was or will be started (indicate medication and dosage): _____

_____

Estimated length of treatment: _____

_____

(Print provider name) (Signature) (Date)

Notice to recipient: This information has been disclosed to you from records protected by federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.