

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Patient Name: _____ DOB _____

Treating Primary Care Practitioner:

Name: _____ Phone: _____

Address: _____ Fax _____

Treating Behavioral Health Clinician/Facility Information:

Name: _____ Phone: _____

Address: _____ Fax _____

This patient is being:

- treated
- referred

for the following conditions:

- ADHD/Behavior D/O
- Anxiety D/O
- Adjustment D/O
- Bipolar D/O
- Depressive D/O
- Eating D/O
- Substance Abuse
- Psychotic D/O
- Other _____

Please complete the following for care coordination purposes.

Dear _____:

Please evaluate this patient for: Medications Other _____

No evaluation requested at this time

Date of patient's initial visit with referring practitioner: _____

My treatment plan (including medications) is: _____

Coordination of care issues/other significant information impacting medical or behavioral health care: _____

Please complete both pages of this form and fax or mail to the corresponding practitioner with whom you are coordinating care.

**CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION BETWEEN
PRIMARY CARE AND BEHAVIORAL HEALTH PRACTITIONERS**

Practitioner Name: _____
Patient Name: _____ **DOB:** _____

I authorize release of the following medical information to the health care practitioner named above. **Check and initial all that apply:**

- Mental Health Diagnosis _____
- Medication Management Information _____
- HIV/AIDS Related Records (Except HIV Test Results) _____
- Other Mental Health Treatment Information _____
- Other information specified here _____
- Substance Abuse (SA) Information _____

- For SA Information, this authorization is:
- Limited to the following treatment _____
 - Limited to the following time period _____

OR

- I do **NOT** wish to have information shared with:
- My PCP/medical practitioner
 - My other behavioral health clinician(s)/practitioner(s)

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulation. Providing consent to release information or not releasing information does not affect your ability to obtain treatment.

I understand that the release of this information is to permit my treating practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time by calling or writing the releasing organization. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

Print Name _____
Date

Signature of Patient or Legal Guardian/Personal Representative *(if signed by a personal representative, please state your authority to act on behalf of the patient.)*

Please fax or mail the completed form to the practitioner with whom you are coordinating care. Please place a copy of this form in the patient's medical record.

- _____ **Date form was *faxed* to practitioner/facility** _____
- _____ **Date form was *mailed* to practitioner/facility** _____
- _____ **Not Applicable-Patient does *not* consent to release of information**