

Agate Passage Psychological Services, Inc. PC

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Behavioral Health and Primary Care Physician/Prescriber Coordination of Care Form

Patient Section

Patient Name: _____ Patient Birthdate: _____

Patient Address: _____

Primary Care Provider (PCP) Name: _____

PCP Address: _____

PCP Phone: _____ Fax Number: _____

Agate Passage Provider Name: _____

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I **authorize** the release/exchange of confidential information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care. I understand that this consent is automatically renewable each year and the confidential information that is exchanged will be kept by the recipient until such time as state law allows destruction of my patient record. I further understand that this authorization may be revoked by me, in writing, at any time, except to the extent that any action has been taken in reliance thereon. I understand that I, and/or my legal representative, are entitled to a copy of this form. I give my permission for release of the following information (Initial all that apply):

Diagnosis and Medications: _____ Behavioral Health Information: _____ HIV Status/STD Diseases: _____

Patient/Legal Guardian Signature: _____ Date _____

+++++ **OR** +++++

I **refuse** to authorize the release/exchange of any behavioral health and medical information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care.

Patient/Legal Guardian Signature: _____ Date _____

Behavioral Health Practitioner Section

I have seen the above named patient for outpatient behavioral health treatment. The following information about the patient's behavioral health care may be helpful for you in managing the patient's medical care.

The patient has been seen on the following dates: _____

The patient's behavioral health diagnosis is: _____

The patient is taking the following medications (with initial date and dosage): _____

Behavioral Health Clinical Information: _____

To the Primary Care Provider (or prescriber): Please provide any medical information that may relate to this patient's behavioral health care. Information useful to this patient's behavioral health care includes: current and/or chronic medical conditions, current medications and dosages, sensitivities to medications and/or psychosocial stressors (e.g. loss of job, injuries, financial stress, parenting problems, etc.) and well as any prescribed limitations of activity or diet. Please call me if you wish to discuss this patient's care further or if you need further information. Thank you.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal and State laws regarding confidentiality. In accordance with those laws, the information received pursuant to this document is confidential and the recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any 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. Federal law restricts the use of this information to criminally investigate or prosecute members who are being treated for substance abuse.