Agate Passage Psychological Services, Inc. PS

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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/PROTECTED HEALTH 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 the 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 confidentiality and coordination of my behavioral health care and my general medical care.

Patient/Legal Guardian Signature: ______________________________ Date: ______________

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Behavioral Health Provider 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): ______________________________

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Behavioral Health Clinical Information: ______________________________

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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.) as 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.

Note 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 the 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 member who are being treated for substance abuse.