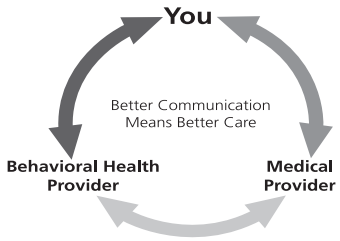
Behavioral Health/Medical Provider Communication Form

(Complete additional forms as needed for each provider.)



Patient Information

Patient name (last, first, m.i.)				Patient birth date (mm/dd/yyyy)	Patient insurance ID number
Patient street address	City	State	ZIP code		Daytime telephone number

Provider Information

☐ Patient does not have a medical provider.

Medical provider name				Medical provider telephone number	Best time to reach me
Patient street address	City	State	ZIP code		Daytime telephone number
Behavioral health provider name				BH Provider telephone number	Best time to reach me
Behavioral health street address	City	State	ZIP code		BH provider fax number

Medical and Behavioral Health Providers: Use the section below to communicate important information about the patient.
Please retain original in patient's record and send a copy to the medical/behavioral health provider.

Patient diagnosis	Comments
Patient medications/herbal remedies and dosages	
Risks/concerns (homicidal/suicidal ideation, etc.)	Comments

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: _____
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of my signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT, PLEASE CHECK ONE:

☐ To release any applicable medical information to my behavioral health provider.
☐ To release any applicable mental health/substance abuse information to my medical provider.
☐ To release only medication information to my medical provider.
☐ I DO NOT give my authorization to release any information to my medical provider.

Patient signature	Date

NOTICE TO RECIPIENT(S) OF INFORMATION:

Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

All patient care and related decisions are the sole responsibility of the treating provider.