Medical and Behavioral Health: Confidential Information Exchange Authorization

The exchange of information between medical and behavioral health providers encourages safe and efficient coordination of care for patients. **Please complete this form and send it to the requesting provider.**

Patient name (First MI Last): _____ **Birth Date** (mm/dd/yyyy): _____

Information provided to the following requesting provider

Provider type: ☐ Medical provider ☐ Behavioral health provider

Name: _____ Phone: _____

Street address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Information released by the following provider

Provider type: ☐ Medical provider ☐ Behavioral health provider

Name: _____ Phone: _____

Street address: _____ Fax: _____

City: _____ State: _____ Zip: _____

Patient diagnosis: _____

Patient medications/other treatment (psychotherapy, skills training, DBT, etc.):

_____

Expected length of treatment: ☐ Less than 3 months ☐ 3-6 months ☐ 6-12 months ☐ More than a year

Coordination of care issues or other significant information regarding medical or behavioral health care:

_____

☐ Please see attached clinical notes

Patient Authorization

I authorize the medical or behavioral health provider listed above to release information contained on this form to the requesting provider listed, to facilitate the continuity and coordination of treatment. This consent shall expire one year from the date signed. I understand that I may revoke my consent at any time and understand that a revocation will not affect a disclosure made in reliance on this form prior to my revocation.

I have read and understand the above information and give my authorization (please check one):

- ☐ Release applicable information to my behavioral health practitioner
- ☐ Release applicable mental/behavioral health information to my medical practitioner
- ☐ I do not give my authorization to release any information to my medical practitioner
- ☐ HIV/AIDS test or result information and related records
- ☐ Mental health information
- ☐ Genetic testing information
- ☐ Drug/alcohol diagnosis, treatment, or referral information

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Relationship to member: ☐ Parent ☐ Legal guardian