BEHAVIORAL HEALTH PROVIDER AND PRIMARY PHYSICIAN COMMUNICATION FORM

Member Name: ______________________________ Date of Birth: ______________

Insurance Plan: ______________________________ Insurance ID#: ______________

Member Consent to Exchange Information:

I ______________________, as member/authorized representative of the member listed, I **AUTHORIZE/DO NOT AUTHORIZE** the exchange of information regarding the mental health treatment or medical healthcare for coordination of care purposes. I understand the shared information will disclose all mental health related information including, but not limited to: diagnosis, assessments, evaluations, and treatment plans. I understand it is my responsibility to notify the behavioral health providers of changes in my physician. I understand this authorization will remain in effect until the termination of mental health services or course of treatment. I understand I may revoke this authorization at any time by written notice.

______________________________ ______________

I authorize communication with Primary Care Physician Signature/Relationship to Member — Date

______________________________ ______________

I DO NOT authorize communication with Primary Care Physician — Date

______________________________ ______________

I currently DO NOT have a Primary Care Physician — Date

Attention Physician: The patient listed below is currently receiving behavioral health services and has consented to share the following information. In an effort to increase communication and promote care coordination between providers, we ask that you review the behavioral health information in Section A. *Please complete and return the medical information in Section B*. Feel free to call with any concerns or questions.

Section A

Mental Health Provider/Agency	*Mental Health Services and Frequency Provided to Member*	*Address*	*Contact Number*	*Fax Number*

1) DSM Diagnosis: ______________________________

2) Current Treatment Goals/Approximate Date of Completion: ______________________________

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3) Current Known Medication/Dosage:

Behavioral Health Medication	**Dosage**	**Reason for Medication**	**Prescribed Physician**

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Member Name: ______________________________ Date of Birth: ____________________

Insurance Plan: ______________________________ Insurance ID#: ____________________

Section B

Please complete the following information and fax back to the mental health providers within 3 business days:

Physician's Name: ____

Address: ____

Physician's Office Contact Person: ____________________ Phone: ______________ Fax: ______________

Copy of Patient's Last Physical and Date of Last Appointment: ______________________________

Prescribed Medication/Dosage/Reason for medication: ______________________________

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Medical Information/Concerns/Allergies: ______________________________

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Signature of Person Completing Form: ______________________________