CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Patient Name: ________________________________ **Member ID Number:** _______________________________

A. Treating Behavioral Health Clinician/Facility Information

Name: ____________________ Phone: ____________________

Address: ____________________ Fax: ____________________

B. Primary Care Physician/Medical Clinician Information OR other Behavioral Health Clinician:

Name: ____________________ Phone: ____________________

Address: ____________________ Fax: ____________________

1. The Patient is being treated for the following behavioral health problem(s):

☐ ADHD/Behavior D/O ☐ Anxiety D/O ☐ Adjustment D/O ☐ Bipolar Disorder D/O

☐ Depressive D/O ☐ Eating Disorder ☐ Substance Abuse ☐ Personality D/O

☐ Psychotic Disorder ☐ Other: ____

2. Outpatient care is being delivered and the treatment plan consists of (check all that apply):

☐ Individual Psychotherapy ☐ Couples Therapy ☐ Family Therapy

☐ Group Therapy ☐ Medication Management ☐ Other: ___________________________________

3. Expected length of treatment: ☐ < 3 months ☐ 3-6 months ☐ 6-12 months ☐ > 1 year

4. Medication (s) are being managed by: ____

Medication(s) and Dosage(s):

1. _______________________________________ 2. ____
3. _______________________________________ 4. ____
5. _______________________________________ 6. ____

Coordination of care issues/other significant information impacting medical or behavioral healthcare:

____

____

____

____

Please complete both sides of this form

Confidential: Not to be re-released without the written consent of the patient to whom this applies.

© 2007 United Behavioral Health

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIANS AND/OR OTHER HEALTH CARE PRACTITIONERS

Primary Care Physician/Health Care Practitioner Name: ________________________________

Patient Name: ___________________________ Member ID Number: ____________________

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. **Check and initial all that apply:**

☐ Mental Health Diagnosis _______

☐ Medication Management Information _______

☐ HIV/AIDS Related Records (Except HIV Test Results) _______

☐ Other Mental Health Treatment Information _______

☐ Other information specified here ____

☐ Substance Abuse (SA) Information _______

For SA Information, this authorization is:

☐ Limited to the following treatment ____

☐ Limited to the following time period ____

OR

☐ I do **NOT** wish to have information shared with:

☐ My PCP/medical practitioner ☐ My other behavioral health clinician(s) /provider(s).

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other heath care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

________________________________ ________________

Signature of Patient or Legal Guardian Date

Send completed form to the physician, not to United Behavioral Health.

Please place a completed copy of this form in the patient's medical record.

DATE FORM ☐ MAILED or ☐ FAXED TO OTHER CLINICIAN / FACILITY: __________________

☐ NOT APPLICABLE – PATIENT DOES NOT CONSENT TO RELEASE OF INFORMATION.

Please complete both sides of this form

Confidential: Not to be re-released without the written consent of the patient to whom this applies.

© 2007 United Behavioral Health