BEHAVIORAL HEALTH AND PRIMARY CARE PHYSICIAN (PCP) COORDINATION OF CARE FORM

BEHAVIORAL HEALTH PRACTITIONER INSTRUCTIONS: Please have your patient complete the patient section of this form. If your patient consents to the release of information, then please complete the practitioner section of this form, retain a copy for your records and HAI/Magellan audit purposes. Mail the completed form to the patient's PCP. If your patient refuses to consent to the release of information, then do not complete the practitioner section of this form, but retain a copy of this form for your records. Incomplete or illegible forms will be returned for correction.

PATIENT SECTION

Patient Name:_____ Patient Birth Date:_____

Patient Address, City, State, Zip:_____

Name of Patient's Primary Care Physician (PCP):_____

PCP's Address. City, State, Zip:_____

Phone #:_____ Fax #:_____ PCP Office # (listed on member's ID card) (Aetna Members Only) _____

Name of Behavioral Health Practitioner: Kerri A. Shaw, MSW, LISW License Type:_____

BH Practitioner's Address, City, State, Zip: 17 Blue Line Drive, Athens, Ohio 45701

Phone #: 740-592-5689 Fax #: 740-593-7166

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL 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 that the confidential information that is exchanged will be kept by the recipient until such time as 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:

☐ Diagnosis and Medications _____ initial ☐ Behavioral Health Information _____ initial

*Patient/Legal Guardian Signature:*_____ *Date:*_____

*****Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.**

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 continuity and coordination of my behavioral health care and my general medical care.

*Patient/Legal Guardian Signature:*_____ *Date:*_____

*****Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.**

BEHAVIORAL HEALTH PRACTITIONER SECTION

Dear Primary Care Physician: 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 *(specify dates):*_____

The patient's behavioral health diagnosis is:_____

The patient is taking the following medications *(list medications and dosage):*_____

Behavioral Health Clinical Information *(attach additional sheets if necessary):*_____

PCP INSTRUCTIONS: Please provide any medical information that may relate to this patient's behavioral health care to the behavioral health practitioner listed above. Examples of information that may relate to a patient's behavioral health care include: 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.). Please call me if you wish to discuss this patient's care further or if you need additional information. Thank you.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal and State laws regarding confidentiality. In accordance with Federal and State laws, the information received pursuant to this document is confidential and the recipient is prohibited from making further re-disclosure of this 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 members who are being treated for substance abuse.

Original - Mail to PCP (only if patient consents) **Copy - BH Practitioner**