Behavioral Health/Primary Physician Patient Care Communication Form

Patient Name:	Date of birth:
Primary Physician Information Name: Address: ☐ Patient does not have a primary physician	**Behavioral Health Clinician Information** Name: JANE Z. WOODROW, PH.D. Address: 507 Richland Ave., Ste. 203A Athens, Ohio 45701-3700 Phone: (740)592-5689 (740) 593-7166

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that records or information about my mental health or alcohol and drug abuse treatment and counseling are confidential; they are protected by applicable state and federal laws, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV infection, and AIDS-Related Complex and the performance of any tests, counseling, and the results and treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 60 days from the date signed.

To Patient: Please check one option below: I, _____
(Print patient's name)

A. ___ DO authorize any information on my care to be shared between the providers listed above to facilitate my treatment.

B. ___ DO authorize information on my care with the following limitations (check any):
☐Medications only ☐Information to primary physician only ☐Other _____

C. ___ DO NOT authorize any information on my care to be shared between my behavioral health clinician and my primary physician, names above, for the purpose of facilitating my treatment.

_____ _____
Signature of patient or guardian Date

To be completed by Behavioral Health Clinician (if the patient authorized disclosure)

Diagnosis and/or brief description of presenting problem:

_____

Treatment Plans/Recommendations:

_____

Current Psychotropic Medications:

_____

Comments/information requested from primary physician:

_____

Behavioral Health Clinician Signature: Date:

To be completed by the Primary Physician (if patient authorized disclosure)

Please provide the information requested as well as any other information relevant to this patient's treatment (attach pages or forms from patient's chart as needed):

Primary Physician Signature: Phone/Fax: Date:

To providers: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and certain state laws. The Federal rules and the state laws prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

This form prepared by The Health Improvement Collaborative of Greater Cincinnati in collaboration with behavioral health providers. This form may be copied or reprinted.