

Patient Consent to Exchange Information

This form is used for authorization to exchange information between healthcare providers and behavioral health providers. Please read the information below and indicate whether consent is given or declined to exchange information. The sole purpose is for continuity and coordination of care between the behavioral health providers and the healthcare providers. This form may be used with all insurance carriers.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

I. Patient Consent Given

I understand the importance of communication between my healthcare provider and behavioral health provider. I give my consent to exchange information for continuity and coordination of care purposes. I understand the information on this form will only be communicated to my healthcare provider and may be faxed with the appropriate confidentiality cover sheet. *This consent expires after one year from the date of signature.* I may receive a copy of this consent upon request. Further disclosure requires my additional authorization, unless allowed for by law.

| | |
|-------------------------------|-----------------------|
| Print Patient Name | Patient Date of Birth |
| Patient or Guardian Signature | Date |

Healthcare Provider Information

| | |
|------------------|--------------|
| First Name | Last Name |
| Street Address | City / State |
| Telephone Number | Fax Number |

The section below shall be completed by the behavioral health provider.

Dear Healthcare Provider,

I am the behavioral health provider for the above named patient, who was seen on _____ with
diagnosis _____ . The treatment recommendations, including lab tests, are: _____
Date
ICD9 Code (s)

The prescribed medication (s) are: _____

If I am not the prescribing provider, the prescribing provider is _____
Prescribing Provider

You may contact me at the phone number listed below.

| | |
|---------------------------------------|------------------|
| Print Behavioral Health Provider Name | Telephone Number |
| Behavioral Health Provider Signature | Date |

II. Patient Consent Declined

My behavioral health provider has explained the importance of communication between providers. At this time, I DO NOT give my consent to exchange information for the following reason:

Declined to Provide Reason

| | |
|-------------------------------|-----------------------|
| Print Patient Name | Patient Date of Birth |
| Patient or Guardian Signature | Date |