



Coordination of Care Form

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

I, _____, _____ authorize
Member Name— Please print Date of Birth
_____, to release health information related to my evaluation
Provider Name—Please Print
and treatment to : _____
PCP or other practitioner name— please print phone number

Information to be completed by Behavioral Health Provider

The following treatment is being provided:

_____ Outpatient Therapy Frequency _____

- Individual Psychotherapy
- Family Psychotherapy
- Group Psychotherapy
- Couples Therapy
- Other

_____ Medication Management Frequency: _____

Medications and Dosages: _____

_____ Intensive Outpatient Frequency _____

_____ Inpatient Treatment

_____ Partial Hospitalization

_____ Residential Treatment

If you have any questions or would like to discuss this case in greater detail, please call me at:

_____ Phone Number

Provider Printed Name

Provider Signature

Provider Licensure

Date

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care I may receive. This authorization, becomes effective on the date signed and may be revoked by me at any time in writing, except to the extent action has been taken and reliance hereon.

All parties agree to comply with Protected Health Information pursuant to HIPAA regulations contained in 45CFR Parts 160 and 164. This authorization also authorizes the release of information under the California Confidentiality of Medical Information Act of 1980, Section 56 et.seq. of the California Code.

Signature of Patient or Legal Guardian

Date

Printed Name of Patient

Send completed form to PCP and/or other practitioner and keep original in treatment record.