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Coordination of Care between Health Care Providers and Release of Information

Patient Name: _____ Patient DOB: _____

Communication between mental health care providers and your primary care physician (PCP), other mental health (MH) providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your mental health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting me.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize Glen F. Pastores to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires one (1) year from the date of my signature below unless otherwise stated herein.

Glen F. Pastores is authorized to release protected health information related to the evaluation and treatment of the patient/member indicated at the top of this form.

Primary Care Physician: _____ **PCP Phone:** _____
PCP Address: _____ **Fax:** _____

Mental Health Provider: _____ **MH Provider Phone:** _____
MH Provider Address: _____ **MH Provider Fax:** _____

Disclosure may include the following verbal or written information: (check all that apply)

Medication records___ Mental health/psychological consult___ Psychological eval/testing results___ Psychiatric evaluation___
Psychosocial assessment___ Substance abuse treatment record___ Communication relating to coordination of care___
Summary of treatment records & contact dates _____ Other_____

____ I do not have, or am not receiving services from a PCP or MH Provider at this time and no authorization is required.

____ I hereby refuse to give authorization for any release of information to my PCP or MH Provider

(Signature of Patient, Parent, Guardian or Authorized Representative)

(Date)

Witness: _____