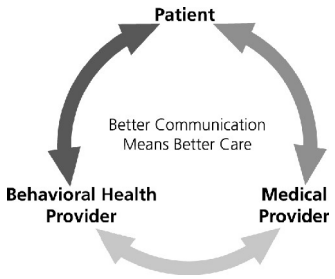
Behavioral Health/Medical Provider Communication Form



Patient Information

Patient Name (Last, First, M.I.)			Patient Birthdate (MM/DD/YYYY)	Patient Insurance ID Number
Patient Street Address	City	State	ZIP Code	Daytime Telephone Number ( ) -

Provider Information

☐ Patient does not have a medical provider.

Medical Provider Name			Medical Provider Telephone Number ( ) -	Best Time to Reach Me
Medical Provider Street Address	City	State	ZIP Code	Medical Provider FAX Number ( ) -
Behavioral Health Provider Name			BH Provider Telephone Number ( ) -	Best Time to Reach Me
Behavioral Health Provider Street Address	City	State	ZIP Code	BH Provider FAX Number ( ) -

Medical and Behavioral Health Providers: Please use the section below to communicate important information about the patient. **Please retain original in patient's record and send a copy to the Medical/Behavioral Health Provider.**

Patient Diagnosis Patient medications/herbal remedies and dosages	Comments
Risks/concerns (homicidal/suicidal ideation, etc.)	Comments

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: _____
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and not longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire six months from the date of the signature, unless another date is specified. I have read and understand the above information and give my authorization:

PATIENT, PLEASE CHECK ONE:

☐ To release any applicable medical information to my behavioral health provider.
☐ To release any applicable mental health/substance abuse information to my medical provider.
☐ To release only medication information to my medical provider.
☐ I DO NOT give my authorization to release any information to my medical provider.

Patient Signature _____ **Date** _____