



CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Family Houston requires its behavioral health practitioners to coordinate treatment with other medical practitioners involved in a client's care. This form is used to facilitate coordination of care between providers involved in the client's care.

PATIENT NAME: _____ DOB: _____

A. Medical Provider (Psychiatrist or Specialist)

Name: _____ Phone: _____

Address: _____ FAX: _____

B. Medical Provider (Primary Care Physician)

Name: _____ Phone: _____

Address: _____ FAX: _____

I do NOT want to have information shared with:

my Psychiatrist/Specialist my Primary Care Physician
 I am not currently receiving services from a PCP/ Specialist/other Medical Practitioner.
 Not relevant for behavioral health treatment

I do want to have information shared:

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed below to release the information contained on this form to the practitioner/provider listed in section A & B above (unless declined above). The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

Patient Signature / Date

Family Houston Clinician Signature / Date

Name in Print

This section will be filled out by Family Houston staff:

1. The patient is being treated by _____ Phone: _____
for the following behavioral health problem(s):

ADHD/ Behavior D/O Psychotic Disorder Depressive D/O Anxiety D/O
 Adjustment D/O Relationship Distress Bereavement OTHER: _____

2. Expected length of treatment: <3 months 3-6 months 6-12 months

3. Coordination of care issues impacting medical or behavioral health care: None Attached

DATE MAILED/FAXED TO OTHER PROVIDER: _____
(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.