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.

Form revised 10-17-18