Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. 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 the practitioner's office.

• If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

• 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 the name(s) or entities written below 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 following 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 in six (6) months from the date of my signature below unless otherwise stated herein.**

Aida R. Coffey MD. is authorized to release protected health information related to the evaluation and

treatment of _____ _____ _____
(Member Name) (Member ID#) (Date of Birth – MM/DD/YYYY)

Primary Care Provider Name:
_____

PCP Address: _____ _____
(Street) (City) (State) (Zip Code)

Therapist Name: _____ Therapist Phone: _____

Therapist Address: _____ _____ _____
(Street) (City) (State) (Zip Code)

Other Name: _____ Other Phone: _____

Other Address: _____ _____ _____
(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply)
_____Laboratory/diagnostic testing results _____Medication records_____ Behavioral health/psychological consult
_____Psychiatric evaluation _____Psychosocial assessment _____Other_____Substance abuse treatment record
_____Summary of treatment records & contact dates

___ **I hereby refuse to give authorization for any release of information**

Signature Date