Exchange of Information Form

This is not a request for medical records.

CDPHP requires contracted behavioral health providers to coordinate treatment with primary care practitioners (PCPs) and other behavioral health providers involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

Date mailed or faxed to other clinician/facility: ____________________

Patient Name: ______________________________ **DOB:** ____________________

Treating Behavioral Health Clinician/Facility Information:

Name: ______________________________ Phone: ____________________

Address: ______________________________ Fax: ____________________

PCP or Other Behavioral Health Clinician/Facility/Information:

Name: ______________________________ Phone: ____________________

Address: ______________________________ Fax: ____________________

Please be advised that I saw a patient from your practice for a medical/mental health/substance evaluation:

Diagnostic description: ______________________________

____

Medications: ______________________________

____

Other treating health care professionals involved in this patient's treatment: ______________________________

____

Treatment recommendations:

- ☐ Individual Therapy
- ☐ Medication Management
- ☐ Family Therapy
- ☐ Medical Treatment
- ☐ Group Therapy
- ☐ Substance Abuse Treatment
- ☐ Couples Therapy
- ☐ Other: ______________________________

If you have any questions, please feel free to contact me.

Sincerely,

______________________________ ____________________ ____________________

Print Name Credentials Phone Number

To the party receiving this information: If information is disclosed from alcohol or substance abuse records protected by Federal confidentiality rules (42 CFR Part 2), those rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by these rules.

Member Consent: I hereby authorize the behavioral health clinician/facility listed above to release the information contained on this form to the practitioner/provider listed 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 in writing at any time except to the extent that the practitioner or entity which is to make the disclosure has already acted in reliance on it. I understand that my treatment is not conditional in any way on my consenting to this disclosure.

Place a completed copy of this form in the patient's medical record and provide signed copy to the patient.

I do not want to have information shared with:

- ☐ My PCP/medical practitioner.
- ☐ My other behavioral health practitioner(s)/provider(s)
- ☐ I am not currently receiving services from a PCP/other medical practitioner.
- ☐ I am not currently receiving services from any other behavioral health practitioner/provider.

______________________________ ____________________

Patient Signature *(If other than patient, state relationship to patient)* **Date**

______________________________ ____________________

Clinician/Facility Representative Signature **Date**

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