Medical and Behavioral Health Providers
Confidential Exchange of Information Form

The exchange of information between medical and behavioral health providers encourages safe and efficient coordination of care for patients. This form is provided as a sample template. Before using this form, please ensure it complies with your policies and any laws that apply to you. **Please complete this form and send it to the requesting provider.**

Patient Full Name: (first, m.i., last)	**Patient Birth Date:** (mm/dd/yyyy)

Requesting Provider: **Medical / Behavioral Health Provider (Circle** provider type**)**

Provider name				Phone number
Street address	City	State	ZIP code	Fax number

Information Provided By: **Medical / Behavioral Health Provider (Circle** provider type**)**

Provider name				Phone number
Street address	City	State	ZIP code	Fax number

Patient diagnosis:

□ ADHD / Behavior Disorder □ Substance Abuse □ Psychotic Disorder □ Bipolar Disorder
□ Depressive Disorder □ Anxiety Disorder □ Eating Disorder □ Adjustment Disorder
□ Personality Disorder □ Other: _____

Patient medications/herbal remedies:

□ Antidepressant - SSRI / Tricyclic / MAOI **(please circle)** □ Antidepressant: (indicate name)_____
□ Antipsychotic - Atypical / Typical **(please circle)** □ Lithium □ Clozaril
□ Anticonvulsant/Mood Stabilizer □ Stimulant □ Anxiolytic
□ Other (indicate medication name):_____

Expected length of treatment: □ <3 months □ 3-6 months □ 6-12 months □ >year

Coordination of care issues / other significant information regarding medical or behavioral health care:

_____
_____

Patient Authorization

I authorize the medical or behavioral health provider listed above to release information contained on this form to the practitioner listed, to facilitate the continuity and coordination of treatment. This consent shall expire one year from the date signed. I understand that I may revoke my consent at any time and understand that a revocation will not affect a disclosure made in reliance on this form prior to my revocation.
I have read and understand the above information and give my authorization:

Patient - please check one:

□ Release applicable information to my behavioral health practitioner
□ Release applicable mental/behavioral health information to my medical practitioner
□ I **do not** give my authorization to release any information to my medical practitioner

Patient signature:	**Date**

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 protected by Federal confidentiality rules (42 CFR Part 2.). The Federal 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 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.