Healthy San Diego

Physical Behavioral Health Coordination Of Care

For Use Between Physical & Behavioral Health Practitioners

SECTION A. CLIENT INFORMATION

Name Last First Middle Initial	AKA	☐ Male ☐ Female
Street Address	Date of Birth	
City	Telephone #	
Zip	Alternate Telephone #	

SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION

Name		
Organization OR Medical Group		
Street Address	City, State, Zip	
Telephone #	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms		
Current Medications		
Summary of Patient Evaluation (*Use Additional Progress Note if Needed*)	Current Treatment Plan (*Use Additional Progress Note if Needed*)	

SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION

Name		
Organization OR Medical Group		
Street Address	Telephone #	
City, State, Zip	Fax #	
Date of Initial Assessment	Diagnosis	Diagnosis
Current Symptoms (*Use Additional Progress Note if Needed*)		
Current Medications (*Use Additional Medication/Progress Note if Needed*)		
Summary of Patient Evaluation (*Use Additional Progress Note if Needed*)	Current Treatment Plan (*Use Additional Progress Note if Needed*)	

TO REACH A PLAN REPRESENTATIVE

Care1st Health Plan	Community Health Group	Health Net	Kaiser Permanent	Molina Healthcare	Access & Crisis Line
(800) 605-2556	(800) 404-3332	(800) 675-6110	(800) 464-4000	(888) 665-4621	(800) 479-3339

Sensitive Information: I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

Right to Revoke: I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

Photocopy or Fax:
I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

Redisclosure: If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

Other Rights: I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section164.524.

SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE

SIGNATURE:	DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

Expiration: Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____
If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

- ☐ Information Contained on this form
- ☐ Current Medication & Treatment Plan
- ☐ Substance Dependence Assessments
- ☐ Assessment /Evaluation Report
- ☐ Discharge Reports/Summaries
- ☐ Laboratory/Diagnostics Test Results
- ☐ Medical History
- ☐ Other _____

Client Name (*Please type or print clearly*)

Last:_____**First:**_____**Middle:**_____

The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.

I would like a copy of this authorization ☐ **Yes** ☐ **No** ***Clients Initials*** _____

ID VALIDATION *(For Office Use)*

SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:	DATE:
SIGNATURE OF HEALTH CARE PROVIDER:	DATE:

➔ **Please place a copy of this *Form* in your client's chart**

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