Authorization for Coordination of Behavioral Healthcare

Read this information first
You should complete this form if you wish to authorize your behavioral health provider to exchange information regarding your behavioral health condition to your primary care provider or other behavioral health providers who may be directly involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission.

Step 1: Complete the demographic information for the Provider administering services:

1.

____

Provider and/or Group Practice Name

2.

____

Address City, State, Zip

3. (__ __ __) __ __ __ - __ __ __ __ 4. (__ __ __) __ __ __ - ___ ___ ___ ___

Phone FAX

Step 2: Patient information (completed by Behavioral Healthcare Provider)

5. Behavioral Diagnosis_________________ 6. First Date of Service: _________

7. Significant Findings:

____

____

8. Treatment Plan:

____

(*Individual, Family, Group, Medications*)

9. Treatment Frequency:

____

(*daily, weekly, monthly*)

10. Estimated Length of Treatment: ____________________________________

11. Notification of medication/changes: ____________________________________

12. Conclusion of Behavioral Health Treatment:

Date: ____

BH Treatment completed? Yes No

13. Recommendations:

____

____

____

____

Step 3: Complete your acknowledgement that you understand that:

• You have the right to review the information that is being used or disclosed;
• You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
• The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
• It is your responsibility to notify your Behavioral Healthcare Provider if you choose to change your Primary Care Physician;
• You have a right to revoke this authorization at any time; and
• A statutory privilege for confidential communications between a patient and a licensed psychologist exists. (For New Jersey residents only)

14. ____ ______________
Person receiving services or Personal Representative's signature** Date

15. ____ ______________
Personal Representative's relationship ** Date

*** Attach a copy of the appropriate legal document granting authority*

16. ____ ______________
Provider Signature Date