Behavioral Care and Primary Care Physician (PCP) Coordination of Care Form

PATIENT SECTION

Patient Name: _____ Patient Birth Date: _____ SS #: _____

Patient Address, City, State, Zip: _____

Name of Patient's Primary Care Physician (PCP) / or Other Healthcare Practitioner: _____

PCP's Address, City, State, Zip: _____

Telephone: _____ Fax: _____ Office # (listed on member's ID card): _____

Name of Behavioral Health Practitioner: Peter J. Weingold, M.D.

BH Practitioner's Address, City, State, Zip: 116 N. Robertson Blvd. #806 Los Angeles, CA 90048

Telephone: (310) 854-0183 Fax: (310) 854-5631

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I authorize the release/exchange of confidential information between my behavioral health practitioner, my primary care physician/or other healthcare practitioner to promote the continuity and coordination of my behavioral health care and my general medical care, I understand that this consent is automatically renewable each year and that the confidential information that is exchanged will be kept by the receipt until such time as state law allows destruction of my patient record. I further understand that this authorization may be revoked by me, in writing, at any time, except to the extent that any action has been taken in reliance thereon. I understand that I, and/or my legal representative, are entitled to a copy of this form. I give my permission for release of the following information:

☐ Diagnosis and Medications _____ initial ☐ Behavioral Health Information _____ initial ☐ HIV Status/STD Diseases _____ initial

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.

OR

I refuse to authorize the release/exchange of any behavioral health and medical information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Please sign and date ONE of the signature lines. Do NOT sign both lines.

BEHAVIORAL HEALTH PRACTITIONERS SECTION

Dear Primary Care Physician/or Other Healthcare Practitioner. I have seen the above named patient for outpatient behavioral health treatment. The following information about the patient's behavioral health care may be helpful for you in managing the patient's medical care:

The patient has been seen on the following date *(specify date):* _____

The patient's behavioral health diagnosis is : _____

The patient is taking the following medications *(list medications and dosage):* _____

_____

Behavioral Health Clinical Information *(attach additional sheets if necessary):* _____

_____

Date Mailed _____ Date Faxed _____

PCP/OR OTHER HEALTHCARE PRACTITIONER INSTRUCTIONS: Please provide any medical information that may relate to this patient's behavioral care to the behavioral health practitioner listed above. Examples of information that may relate to a patient's behavioral health care include: current and/or chronic medical conditions, current medications and dosages, sensitivities to medications and/or psychosocial stressors (e.g. loss of job, injuries, financial stress, parenting problems, etc.). Please call me if you wish to discuss this patient's care further or if you need additional information. Thank you.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal and State laws and the recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal law restricts the use of this information to criminally investigate or prosecute members who are being treated for substance abuse.