

**CONTACT BEHAVIORAL HEALTH SERVICES
AUTHORIZATION FOR RELEASE OF INFORMATION TO TREATING PRACTITIONERS**

Xerox
Patient's ID Card
Here

PATIENT AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Your behavioral health practitioner would like to share information with your physicians about your diagnosis, prescribed medications, and other clinical information for care coordination and to assist your physicians in providing appropriate treatment to you. **This may include information about drug or alcohol treatment or about communicable diseases, such as HIV/AIDS status.** After your information is disclosed to another person or company, it may not be protected by the federal privacy rule and could possibly be released to someone else. **You are not required to sign this authorization.** If you do not sign this authorization, it will not affect your treatment, payment, enrollment or eligibility for benefits. You also may cancel this authorization at any time by submitting a request in writing to the address at the bottom of this page, unless your practitioner already released the information. This authorization will automatically expire twelve (12) months from the date of your signature, unless you list an earlier date or expiration event here: _____.

If you agree that your behavioral health practitioner may share your health information with your physicians and other health care providers, sign here:

Patient/Legal Representative Signature: _____ *Date:* _____

Relationship to Patient if signed by Legal Representative: _____

TO THE PATIENT'S HEALTH CARE PROVIDERS

The following information about the patient's behavioral health care may be helpful for you in managing the patient's medical care. You may contact the behavioral health practitioner listed below if you wish to discuss this patient's care further or if you need any additional information. This is not a request for medical records.

BH Practitioner Name (Last, First, MI): _____ License Type: _____

BH Practitioner's Address, City, State, Zip: _____

Phone # (Ten Digits): (____) _____ - _____ Fax # (Ten Digits): (____) _____ - _____

The patient was first seen on the following date (MM/DD/YYYY): ____/____/____, Last seen on: ____/____/____

The patient's primary behavioral health diagnosis is: _____, DSM IV Code: _____

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

Additional Clinical Information (*additional sheets may be attached if necessary*): _____

If this information includes 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.

TO THE BEHAVIORAL HEALTH PRACTITIONER

Please keep a copy of this form for your records and return a copy to CONTACT BEHAVIORAL HEALTH SERVICES, 4645 E. Cotton Center Blvd, Suite 200, Phoenix, AZ 85040, ATTN: Quality Improvement **FAX: 602 414-7171**. If the patient consents to sharing information with the patient's physicians, CONTACT will send a copy to patient's treating physician of record.