



Coordination of Care Form

Release of medical information from _____ to _____
 (Practitioner) (Practitioner)
 located at _____
 (Location of New Practitioner)

Patient Name: _____ DOB: _____
 Member Number/Social Security Number: _____ Phone No. _____
 Physican Phone Number: _____ Fax No. _____

- Records to be released:
- All health records
 - Health records related to drug/alcohol/substance abuse
 - Health records related to emotional/mental/developmental disabilities/psychiatric conditions
(excludes psychotherapy notes)
 - Other: _____

I authorize the above checked records to be released to _____ as indicated above.

 Patient's Signature Date

Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notice in writing. I understand that my healthcare provider(s) may have already released records according to this authorization prior to receiving my notice of cancellation. **Unless cancelled**, this authorization expires: _____

I **do not** authorize information about my physical/behavioral health treatment to be released.

 Patient's Signature Date

Healthcare Coordination Information

Treatment start date: _____ ICD-9-DX: _____
 DSM-IV DX: _____

Medication managed by: _____

- Medication/Dosages:
- 1) _____
 - 2) _____
 - 3) _____
 - 4) _____

Treatment plan: _____

If there is additional information you feel I should know in order to provide the best possible care to this patient, **especially any coexisting medical conditions**, or if you would like to discuss treatment, please contact me.

 Practitioner's Signature Date

 Telephone