PATIENT CONSENT TO EXCHANGE INFORMATION (to be completed by patient)

I, _____ , authorize _____,
(Name of Patient) (Name of Provider)

my behavioral health provider, and _____,
(Name of Primary Care Physician)

to exchange information regarding my mental health/substance abuse treatment and medical healthcare for continuity of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse treatment. I understand this authorization shall remain in effect for one year or throughout the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Parent/Guardian (if patient is a minor) Date

_____ _____
Witness Signature Date

PROVIDER INFORMATION (to be completed by behavioral health provider)

_____ with Family Psychiatric Center LLC, 702 West Alto Road,
(Provider Name) P.O. Box 6459, Kokomo IN 46904
(765)453-7422 (765)453-3773 fax

DSM IV _____ _____ _____

Treatment Plan:
Type_____ Frequency_____ Est. Length of Tx_____
(ind., family, grp, meds) (wkly, mthly)

Comments: _____
_____
_____
(If you need to communicate about an urgent or emergency situation, please call practitioner in addition to sending form)

Notification of prescription or change in medications (details below)
_____
_____

Conclusion of mental health treatment: Date of last session_____ Treatment completed? Yes___ No___

_____
Provider Signature