



## COORDINATION OF CARE

BETWEEN PHYSICAL & BEHAVIORAL HEALTH PRACTITIONERS

| SECTION A. CLIENT INFORMATION                         |       |                                  |                        |  |                                 |
|---|-------|----------------------------------|------------------------|--|---------------------------------|
| Name Last   | First | Middle Initial                   | AKA                    | <input type="checkbox"/> Male              | <input type="checkbox"/> Female |
| Street Address  |       |                                  | Date of Birth          |  |                                 |
| City  |       |                                  | Telephone #            |  |                                 |
| Zip   |       |                                  | Alternate Telephone #  |  |                                 |
| SECTION B. BEHAVIORAL HEALTH PRACTITIONER INFORMATION |       |                                  |                        |  |                                 |
| Name  |       |                                  |                        |  |                                 |
| Organization OR Medical Group                         |       |                                  |                        |  |                                 |
| Street Address  |       |                                  | City, State, Zip       |  |                                 |
| Telephone #   |       |                                  | Fax #                  |  |                                 |
| Date of Initial Assessment                            |       | Diagnosis                        |                        | Diagnosis                                  |                                 |
| Current Symptoms                                      |       |                                  |                        |  |                                 |
| Current Medications                                   |       |                                  |                        |  |                                 |
| Summary of Patient Evaluation                         |       |                                  | Current Treatment Plan |  |                                 |
| SECTION C. PHYSICAL HEALTH PRACTITIONER INFORMATION   |       |                                  |                        |  |                                 |
| Name  |       |                                  |                        |  |                                 |
| Organization OR Medical Group                         |       |                                  |                        |  |                                 |
| Street Address  |       |                                  | City, State, Zip       |  |                                 |
| Telephone #   |       |                                  | Fax #                  |  |                                 |
| Date of Initial Assessment                            |       | Diagnosis                        |                        | Diagnosis                                  |                                 |
| Current Symptoms                                      |       |                                  |                        |  |                                 |
| Current Medications                                   |       |                                  |                        |  |                                 |
| Summary of Patient Evaluation                         |       |                                  | Current Treatment Plan |  |                                 |
| To Reach a Plan Representative                        |       |                                  |                        |  |                                 |
| Blue Cross Of California<br>Community Health Group    |       | Health Net<br>Kaiser Permanente  |                        | Universal Care<br>United Behavioral Health |                                 |
| (800) 407-4627<br>(800) 404-3332                      |       | (800) 675-6110<br>(800) 464-4000 |                        | (800) 635-6668<br>(800) 479-3339           |                                 |



**Sensitive Information:** I understand that the information in my record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or infection with the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol and drug abuse.

**Right to Revoke:** I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released based on this authorization.

**Photocopy or Fax:**

I agree that a photocopy or fax of this authorization is to be considered as effective as the original.

**Redisclosure:** If I have authorized the disclosure of my health information to someone who is not legally required to keep it confidential, I understand it may be redisclosed and no longer protected. California law generally prohibits recipients of my health information from redisclosing such information except with my written authorization or as specifically required or permitted by law.

**Other Rights:** I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. However, if this authorization is needed for participation in a research study, my enrollment in the research study may be denied. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in 45 Code of Federal Regulations section 164.524.

**SECTION D SIGNATURE OF INDIVIDUAL OR LEGAL REPRESENTATIVE**

SIGNATURE:

DATE:

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP OF INDIVIDUAL:

**Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_ If I do not specify an expiration date, event or condition, this authorization will expire in one (1) calendar year from the date it was signed, or 60 days after termination of treatment.

**FOR OFFICE USE**

**ID VALIDATION**

SIGNATURE OF STAFF PERSON VALIDATING IDENTIFICATION:

DATE:

SIGNATURE OF HEALTH CARE PROVIDER:

DATE:

*The above signed authorizes the behavioral health practitioner and the physical health practitioner to release the following medical records and information concerning the patient. The purpose of such a release is to allow for coordination of care, which enhances quality and reduces the risk of duplication of tests and medication interactions. Refusal to provide consent could impair effective coordination of care.*

- o Information Contained on this form
- o Current Medication & Treatment Plan
- o Substance Dependence Assessments
- o Assessment /Evaluation Report

- o Discharge Reports/Summaries
- o Laboratory/Diagnostics Test Results
- o Medical History
- o Other \_\_\_\_\_

**To Reach A Health Plan Representative Call:**

Blue Cross Of California (800) 407-4627  
Community Health Group (800) 404-3332  
Health Net (800) 675-6110  
Kaiser Permanente (800) 464-4000  
United Behavioral Health (800) 479-3339

**Client Name { Please type or print clearly}**

(Last) \_\_\_\_\_

(First) \_\_\_\_\_

**I would like a copy of this authorization.**

Yes  No Initials



**PLACE A COPY OF THIS FORM  
IN THE CLIENT'S MEDICAL RECORD**