author
by Humana

Behavioral Health Release of Information

This form will allow your behavioral health provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug use diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance use records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in six months from the date of my signature below unless otherwise stated herein.

_____ *(Provider Name)* is authorized to release protected health information

related to the evaluation and treatment of _____ *(Member Name)*

_____ *(Member ID Number)* _____ *(Date Of Birth)*

PCP Name: _____ PCP Phone: _____

PCP Address: _____

City: _____ State: _____ Zip Code: _____

BH Provider Name: _____ BH Provider Phone: _____

BH Provider Address: _____

City: _____ State: _____ Zip Code: _____

author
by Humana

Other Name: _____ Other Phone: _____

Other Address: _____

City: _____ State: _____ Zip Code: _____

Disclosure may include the following verbal or written information: *(Check All That Apply)*

_____ Face sheet
_____ Discharge summary
_____ ER record report
_____ Substance use treatment record
_____ History and physical
_____ Medication records
_____ Psychiatric evaluation
_____ Laboratory/diagnostic testing results
_____ Behavioral health/psychological consult
_____ Psychosocial assessment
_____ Summary of treatment records & contact dates
_____ School information
_____ Psychological evaluation /testing results
_____ Other

_____ I hereby refuse to give authorization for any release of information.

Signature of patient, parent, guardian, or authorized representative:

_____ **Date:** _____

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e., power of attorney, living will, guardianship papers, etc.)

author by Humana

Behavioral Health Coordination of Care Form

Completion of this form ensures communication between a patient's behavioral health care providers and other providers. This communication is important to ensure members with service from Author by Humana receive comprehensive and quality healthcare.

I want to inform you that *(Member Name)* _____ **was seen by me for the treatment of:**

DSM-5, ICD-10, and/or medical diagnosis: _____

Date of appointment: _____

Summary: _____

_____

_____

_____

The treatment plan consists of the following modalities:

_____ Individual psychotherapy
_____ Psychological testing
_____ Group psychotherapy
_____ Other *(specify)* _____
_____ Family psychotherapy
_____ Medication management *(see below)*

Current medication(s) *(Dosage, Frequency, and Delivery):*

_____

_____

_____

_____

The following medication was or will be started *(Indicate Medication and Dosage):*

_____

Estimated length of treatment:

_____

author
by Humana

Provider Name *(Print):* _____

Signature: _____ **Date:** _____

Notice to recipient: This information has been disclosed to you from records protected by federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a 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. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.

This form is provided as a sample. It is not being provided to fit a particular set of circumstances, nor is it to be used as a clinical assessment tool. You have the sole responsibility for ensuring that the release of information follows all state and federal requirements and is in accordance with applicable standards of practice for your license/specialty.