OptimaHealth
A service of Sentara

CONFIDENTIAL EXCHANGE OF HEALTHCARE INFORMATION FORM

PATIENT NAME: _____ **DOB:** _____

Practitioner Section:

A. Treating Behavioral Health Practitioner/Provider Information:

Name:	Phone:
Address:	

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Provider Information:

Name:	Phone:
Address:	
Fax:	

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem(s):

- ADHD/ Behavior D/O
- ☐ Adjustment D/O
- ☐ Anxiety D/O
- ☐ OTHER: _____
- ☐ Bipolar D/O
- ☐ Depressive D/O
- ☐ Eating D/O
- ☐ Personality Disorder
- ☐ Psychotic D/O
- ☐ Substance Abuse

2. The patient is taking the following prescribed psychotropic medication(s)?

- ☐ Anticonvulsant/Mood Stabilizer
- ☐ Antidepressant – MAOI
- ☐ Antidepressant – SSRI
- ☐ Antidepressant – Tricyclic
- ☐ Antidepressant –Wellbutrin
- ☐ Antipsychotic- Atypical
- ☐ Antipsychotic – Typical
- ☐ Anxiolytic
- ☐ Clozaril
- ☐ Lithium
- ☐ Stimulant
- ☐ Other_____

3. Estimated duration of treatment: ☐ < 3 months ☐ 3-6 months ☐ 6-12 months ☐ > 1 year

4. Coordination of care issues/ Other significant information impacting medical or behavioral health care:

_____

_____

_____

DATE FORM MAILED OR FAXED TO OTHER PRACTITIONER/ PROVIDER: _____

Patient Section:

☐ I hereby voluntarily, freely and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in Section B above. The reason for this release of information is to assist in the continuity and coordination of my treatment. This consent will automatically last <u>one year</u> from the date signed. I understand that I may reverse my consent at any time.

_____

Patient Signature /Date

I do <u>not</u> wish to have information shared with:

- ☐ My PCP/medical practitioner
- ☐ My other behavioral health practitioner(s)/provider(s)

I am not currently receiving services from:

- ☐ PCP/ medical practitioner
- ☐ Any other behavioral health practitioner/provider

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal law regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of the medical or other information is not sufficient for this purpose

PLEASE PLACE A COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD.