# Medical Release Form for Behavioral Health Information Exchange

## I. General Information

<table>
<thead>
<tr>
<th>Referral Date</th>
<th>DOB</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent:</td>
<td></td>
<td>Pt's Primary Language</td>
</tr>
</tbody>
</table>

## II. Reason(s) for Referral, To be Completed by Referring Health Care Provider. Check all that apply

- [ ] Diagnoses
- [ ] Behavioral Concerns
- [ ] Other Issues

Completed form to be returned to this Referring Health Care Provider

<table>
<thead>
<tr>
<th>Tel # Fax</th>
</tr>
</thead>
</table>

## III. Consent by Adult Patient or Parent / Legal Guardian

I consent to communication and exchange of information between ______________________ and ______________________ to discuss and share records/conditions pertaining to the above.

I understand that this information is generally confidential and may not be given to employees of other institutions, public agencies or individual professionals in private practice without my consent.

Parent/Guardian/Student (Over Age 18) **Name** ______________________ **Date** ______

Parent/Guardian/Student (Over Age 18) **Signature** ______________________

This authorization shall be valid until __________ (date) Please indicate a date after which no information can be released: ________. If no date is given, authorization is valid for one year from date of signature. This consent is voluntary.

To revoke this consent, send a copy to your doctor’s office at:

___________________________________________________________

- [ ] I revoke this consent for communication and exchange of information.

In accordance with the Health Insurance Portability and Accountability Act (HIPPA) and applicable California laws, all personal and health information is private and must be protected.

- [ ] Copy provided to Signer

## IV. Follow-up:

**Dear Behavioral Health Care Provider, Please complete Page 2. Return to Referring Provider indicated above.**
MEDICAL RELEASE FORM FOR BEHAVIORAL HEALTH INFORMATION EXCHANGE

MAY ONLY BE SHARED IN CONJUNCTION WITH THE SIGNED CONSENT FORM

I. GENERAL INFORMATION

Patient: ____________________________ Referral Date ____________________________
DOB: ____________________________ Age: ____________________________

Parent: ____________________________ Pt’s Primary Language: ____________________________

Completed form to be returned to this Referring HealthCare Provider: ____________________________
Tel # Fax: ____________________________

II. REASON(S) FOR REFERRAL TO BE COMPLETED BY REFERRING HEALTH CARE PROVIDER. Check all that apply:

☐ Diagnoses:

☐ Academic Concerns, poor achievement
☐ Behavioral Concerns
☐ With peer group
☐ In school
☐ In family
☐ In the community
☐ Substance Abuse
☐ Trauma
☐ Assault/Abuse
☐ Crisis reaction
☐ Grief

☐ Family Issues
☐ Communications
☐ Conflict
☐ Behavior
☐ Divorce

☐ Other Issues: (including physical, social, family issues)

III. FOLLOW-UP: TO BE COMPLETED BY CONSULTING HEALTH CARE PROVIDER & RETURNED TO REFERRING PROVIDER ABOVE

Diagnoses

Treatments

Medications prescribed? ☐ No ☐ Yes, Specify medication(s) & dose(s)

Additional referral made? ☐ No ☐ Yes, Specify where

What is your follow up plan?

Other information you wish to share with referring provider listed above

Would you like the referring provider to contact you to discuss this pt? ☐ No ☐ Yes

Printed Name and Signature of Provider completing this form: ____________________________
Tel & Fax: ____________________________