MEDICAL RELEASE FORM FOR BEHAVIORAL HEALTH INFORMATION EXCHANGE

I. GENERAL INFORMATION

Referral Date ______

Patient: ______ DOB ______ Age ______

Parent: Pt's Primary Language

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	Tel # Fax

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

Referral Date

Patient: ____ 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

☐ **Gender Identity Issues**

☐ **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