

# EXCHANGE OF INFORMATION FORM

Patient to Complete:

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**A. YOUR PRIMARY CARE PHYSICIAN (PCP)**

Your PCP's Name: \_\_\_\_\_ PCP's Phone #: \_\_\_\_\_

PCP's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

PCP's Fax #: \_\_\_\_\_

I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician/ facility listed below in Section B to release the information contained on this form to the clinician/facility listed in section A above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 30 days from the date signed. I understand that I may revoke my consent at any time.

\_\_\_\_\_  
Patient Signature Date

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**Provider to Complete:**

**B. TREATING BEHAVIORAL HEALTH CLINICIAN/FACILITY**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Fax #: \_\_\_\_\_

**C. Patient Clinical Information:**

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

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> ADHD/ Behavior D/O | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Psychotic Disorder | <input type="checkbox"/> Bipolar D/O    |
| <input type="checkbox"/> Depressive D/O     | <input type="checkbox"/> Anxiety D/O     | <input type="checkbox"/> Eating Disorder    | <input type="checkbox"/> Adjustment D/O |
| <input type="checkbox"/> Mood Disorder      | <input type="checkbox"/> OTHER: _____    |   |   |

2. The patient is taking the following prescribed psychotropic medication/s: \_\_\_\_\_

3. Outpatient care:

- Medication Management    Individual Therapy    Family Therapy    Other: \_\_\_\_\_

4. Expected length of treatment:  <3 months    3-6 months    6-12 months    >1 year

5. Coordination of care issues/Other significant information impacting medical or behavioral healthcare:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Behavioral Health Clinician Date

DATE FORM MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: \_\_\_\_\_

(PLACE A COMPLETED COPY OF THIS FORM ON THE PATIENT'S MEDICAL RECORD)

**THIS IS NOT A REQUEST FOR MEDICAL RECORDS**