COORDINATION OF CARE BETWEEN HEALTH CARE PROVIDERS AND AUTHORIZATION FOR RELEASE OF INFORMATION

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow City to City Psychiatric Services, dba, WellMed to share protected health information (PHI) with your other providers; allow those providers to share information with our practice, and allow us to share information with our own internal providers should you elect to use more than one of our clinicians. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

RE: Patient: _____

Date of Birth: _____

( ) I, the undersigned, do hereby request and authorize the release of medical records/medical information from the following parties to City to City Psychiatric Services, Inc, dba, WellMed., regarding the abovementioned patient.

( ) I the undersigned, do hereby request and authorize the release of medical records/medical information to the following parties from City to City Psychiatric Services, Inc, dba, WellMed. regarding the abovementioned patient.

( ) I the undersigned, do hereby request and authorize the release of medical records/medical information between the providers at City to City Psychiatric Services, Inc, dba, WellMed.. I understand this release is given only in the event that I am using more than one of their providers

____ (1) _____

(Initials) _____

_____

If specific records and/or information are requested, they are indicated as follows: _____

This information is being disclosed from records whose confidentially is protected by Federal regulations (42 CFR Par 2) which prohibit any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical information is not sufficient for this purpose.

A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization and consent is valid until revoked by me in writing and delivered to my doctor. Unless expressly revoked earlier, this consent extends throughout the period necessary to complete all transactions related to services provided me.

I understand that my case information will be made available to my Workers Compensation insurance carrier, rehabilitation provider, Workers Compensation attorney and the State Board of Workers Compensation if my services are being provided through Workers Compensation.

_____ _____

Signature of Patient or Authorized Representative

Relationship to Patient

_____ _____

Witness

Date of Authorization