Psychological & Educational Services, LLC
1351 South County Trail
Building 1 • Suite110
East Greenwich, RI 02818
Tel: 401-398-2434 • Fax: 401-398-2451

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Patient Name: _____ **Member ID Number:**_____

A. Treating Behavioral Health Clinician/Facility Information

Name: Phone: (401) 398-2434

_____

Address: 1351 South County Trail East Greenwich, RI 02818 Fax: (401) 398-2451

_____

B. Primary Care Physician/Medical Clinician Information OR other Behavioral Health Clinician:

Name: Phone:

_____

Address: Fax:

_____

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

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

2. Outpatient care is being delivered and the treatment plan consists of (check all that apply):

☐ Individual Psychotherapy ☐ Couples Therapy ☐ Family Therapy
☐ Group Therapy ☐ Medication Management ☐ Other: _____

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

4. Medication (s) are being managed by:
_____

Medication(s) and Dosage(s):

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Coordination of care issues/other significant information impacting medical or behavioral healthcare:

_____

_____

_____

_____

Confidential: Not to be re-released without the written consent of the patient to whom this applies.

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIANS AND/OR OTHER HEALTH CARE PRACTITIONERS AND/OR SCHOOL

Primary Care Physician/Health Care Practitioner Name: _____

School: _____

Counselor: _____

Other: _____

Patient Name: _____

By initialing all information items I approve, I authorize release of the following medical information to sources named above. **Check and initial all that apply:**

☐ Mental Health Diagnosis _____
☐ Medication Management Information _____
☐ HIV/AIDS Related Records (Except HIV Test Results) _____
☐ Other Mental Health Treatment Information _____
☐ Other information specified here _____
☐ Substance Abuse (SA) Information _____

For SA Information, this authorization is:

☐ Limited to the following treatment _____
☐ Limited to the following time period _____

OR

☐ I do **NOT** wish to have information shared with:

☐ My PCP/medical practitioner ☐ The school/behavioral health clinician(s)/other

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other heath care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Patient or Legal Guardian Date

Send completed form to the physician

Please place a completed copy of this form in the patient's medical record.

DATE FORM MAILED or FAXED TO OTHER CLINICIAN / FACILITY:_____

** NOT APPLICABLE – PATIENT DOES NOT CONSENT TO RELEASE OF INFORMATION**