

Member Name _____ Date of Birth _____

ValueOptions Behavioral Health Provider/Primary Care Physician Communication Form

Member Consent to Exchange Information (to be completed by member) Health Plan: _____

I, _____, authorize/do not authorize _____,
(Please Print) (Circle one) (Provider's Name)

My behavioral health provider, and _____,
(Primary Care Physician Name) (PCP Address and Phone Number)

to exchange information regarding my mental health /substance abuse treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment such as diagnosis and treatment plan. I understand that this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider. I also understand that it is my responsibility to notify my behavioral healthcare provider if I choose to change my Primary Care Physician.

I Authorize Communication between My PCP
and Behavioral Health Provider (Member's Signature)

Date

I Do Not Authorize Communication between My PCP
and Behavioral Health Provider (Member's Signature)

Date

Signature of parent or guardian (if member is a minor)

Date

Witness

Date

Provider Information (to be completed by ValueOptions provider) - Please Print

Practitioner Name(s) Facility Name Address City/State Telephone Number
(Therapist and Psychiatrist if applicable)
DSM IV Diagnosis code & name _____

Treatment Plan: Type _____ Frequency _____ Est length of Tx _____
(I.e. ind, family, group, meds) (i.e. weekly, etc)

Medication(s) Prescribed: _____

Comments: _____

For urgent or emergency situation, please call the primary care physician in addition to sending form

- Conclusion of mental health/substance treatment
- Date of last session _____ Treatment completed? Yes ___ No ___
- Notification of prescription or change in medications (see comments)
- Other: _____

Print Clinician Name Signature/Credentials Telephone Number

A COPY OF THIS FORM MUST BE SENT TO THE PRIMARY CARE PHYSICIAN, RETAINING THE ORIGINAL IN THE MEMBER'S CHART. IF THE FORM IS SENT BY FAX, ATTACH CONFIRMATION THAT FAX WAS SENT. Please Check Method

DATE SENT SENT BY (CLINICIAN PLEASE INITIAL) Fax Mail

