Behavioral Health/Medical Provider Communications Form

FAX TO: 532-6999 (Oahu)/1-800-688-4040 (Neighbor Islands)

To ensure continuity and coordination of care between the Primary Care Physician (PCP) and Behavioral Health provider, please use this form to obtain a signed consent from the member.

Patient Information

Patient Name (Last, First, M.I.)	Patient birthdate	Member I.D. number	Daytime Phone Number

Provider Information

Medical Provider Name				Medical Provider Phone Number	Best time to reach me
Street Address	City	State	Zip Code		Fax Number
Behavioral Health Provider Name				BH Provider Phone Number	Best time to reach me
Street Address	City	State	Zip Code		Fax Number

Use the section below to communicate important information about the patient. Attach a separate sheet if more space is needed for medications.

Patient medications/herbal remedies	Dosage	Frequency
Patient medications/herbal remedies	Dosage	Frequency
Comments		

Patient Rights

You can end this authorization (permission to use or disclose information) any time.

- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous consent.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been taken in reliance upon it and that in any event, this consent shall expire 12 months from the date of my signature, unless another date is specified_____.
(specify date)

I have read and understand the above information and give my authorization:

PATIENT—PLEASE INITIAL ALL THAT APPLY:

_____ To release any applicable medical information to my behavioral health provider.

_____ To release any applicable mental health/substance abuse information to my medical provider.

_____ To release only medication information to my medical provider.

_____ I authorize that the following Protected Health Information be Used/Disclosed: (Be specific. Identify limits, as appropriate, if your authorization includes the use/disclosure of specially protected health Information.

_____ Mental health _____ Substance abuse treatment _____ HIV/AIDS

Limitations:_____

_____ I DO NOT give my authorization to release any information to my medical provider.

Patient Signature	Date

NOTICE TO RECIPIENT(S) OF INFORMATION:
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient. All patient care and related decisions are the sole responsibility of the treating provider.

File original in patient's record and send a copy to the PCP or Behavioral Health provider and MDX Hawai'i.