# FPMG CONFIDENTIAL EXCHANGE OF INFORMATION FORM

FPMG requires contracted behavioral health practitioners and providers to coordinate treatment with other behavioral health practitioners and providers, primary care practitioners (PCPs), and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member.

**PATIENT NAME: _____ DOB: _____**

PCP: _____

Address: _____

Phone: _____ Fax:

**1. The patient is being treated for the following behavioral health problem(s):**
□ ADHD/ Behavior D/O □ Substance Abuse □ Psychotic Disorder □ Bipolar D/O □ Depressive D/O □ Anxiety D/O □ Eating Disorder □ Adjustment D/O □ Personality D/O □ OTHER: _____

**2. The patient is taking the following prescribed psychotropic medication(s):**
□ Antidepressant-SSRI □ Antidepressant-Tricyclic □ Antidepressant-MAOI □ Antidepressant-Wellbutrin □ Lithium □ Antipsychotic-Atypical □ Antipsychotic-Typical □ Clozaril □ Stimulant □ Anxiolytic □ Anticonvulsant/Mood Stabilizer □ Other (Indicate medication name): _____

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

**4. Coordination of care issues/Other significant information impacting medical or behavioral health care:**

_____

_____

_____

**DATE MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____**

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

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above to release the information contained on this form to the practitioner/provider listed. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

**Patient Signature: _____ Date: _____**

**Behavioral Health Clinician/Facility Representative Signature Date: _____**

**I do not want to have information shared with:**

□ my PCP/medical practitioner. □ my other behavioral health practitioner(s)/provider(s).
□ I am not currently receiving services from a PCP/ other medical practitioner.
□ I am not currently receiving services from any other behavioral health practitioner/provider.

**For Patient Records Applicable Under Federal Law 42 CFR Part 2**

**To the party receiving this information:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making 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 or other information is not sufficient for this purpose.

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