Sentara® Health Plans

PO Box 66189
Virginia Beach, VA 23466

# CONFIDENTIAL EXCHANGE OF HEALTHCARE INFORMATION FORM

**Patient Name:** _____ **DOB:** _____

| **Practitioner Section:** | |
|---|---|
| ***A. Treating Behavioral Health Practitioner/Provider Information*** | |
| Name: | Phone: |
| Address: | |
| ***B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Provider Information:*** | |
| Name: | Phone: |
| Address: | |
| Fax: | |
| ***C. Patient Clinical Information:*** | |

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

- ☐ ADHD/Behavior D/O
- ☐ Adjustment D/O
- ☐ Anxiety D/O
- ☐ Bipolar D/O
- ☐ Depressive D/O
- ☐ Eating D/O
- ☐ Personality D/O
- ☐ Psychotic D/O
- ☐ Substance Abuse
- ☐ Other_____

**2. The patient is taking the following prescribed psychotropic medication(s):**

- ☐ Anticonvulsant/Mood Stabilizer
- ☐ Antidepressant – MAOI
- ☐ Antidepressant – SSRI
- ☐ Antidepressant – Tricyclic
- ☐ Antidepressant – Wellbutrin
- ☐ Antipsychotic – Atypical
- ☐ Antipsychotic – Typical
- ☐ Anxiolytic
- ☐ Clozaril
- ☐ Lithium
- ☐ Stimulant
- ☐ Other

**3. Estimated duration of treatment:**

☐ < 3 months ☐ 3–6 months ☐ 6–12 months ☐ > 1 year

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

_____

_____

_____

**Date Form Mailed or Faxed to Other Practitioner/Provider:** _____

**Patient Section:**

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

_____

**Patient Signature/Date**

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

☐ My PCP/medical practitioner

☐ My other behavioral health practitioner(s)/provider(s)

**I am not currently receiving services from:**

☐ My PCP/medical practitioner

☐ Any other behavioral health practitioner/provider

**To the party receiving this information:** This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal law regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of the medical or other information is not sufficient for this purpose.

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