Patient Consent to Exchange Information

This form is used for authorization to exchange information between healthcare providers and behavioral health providers. Please read the information below and indicate whether consent is given or declined to exchange information. The sole purpose is for continuity and coordination of care between the behavioral health providers and the healthcare providers. This form may be used with all insurance carriers.

I Patient Consent Given

I understand the importance of communication between my healthcare provider and behavioral health provider. I give my consent to exchange information for continuity and coordination of care purposes. I understand the information on this form will only be communicated to my healthcare provider and may be faxed with the appropriate confidentiality cover sheet. This consent expires after one year from the date of signature. I may receive a copy of this consent upon request. Further disclosure requires my additional authorization, unless allowed for by law.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Patient or Guardian Signature Date

Healthcare Provider Information

First Name Last Name

Street Address City / State

Telephone Number Fax Number

The section below shall be completed by the behavioral health provider.

Dear Healthcare Provider, I am the behavioral health provider for the above named patient, who was seen on _____ with diagnosis _____
The treatment recommendations are:_____
Possible medication (s) that may be of help are:_____

_Michael H. Foust, Ph.D._____ _714-834-9222 ezt 4_____
Print Behavioral Health Provider Name Telephone Number

_____ _____
Signature Date

II **Patient Consent Declined**

My behavioral health provider has explained the importance of communication between providers. At this time, I DO NOT give my consent to exchange information for the following reason:

[ ] Declined to Provide Reason

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Patient or Guardian Signature Date