OPTUM®

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Optum requires contracted behavioral health practitioners and facilities to coordinate treatment with other behavioral health practitioners, primary care physicians (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:**

A. Treating Behavioral Health Clinician/Facility Information:

Name: Phone:

Address: Fax:

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:

Name: Phone:

Address: Fax:

C. Patient Clinical Information:

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

☐ ADHD/ Behavior Disorder ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar Disorder
☐ Depressive Disorder ☐ Anxiety Disorder ☐ Eating Disorder ☐ Adjustment Disorder
☐ Personality Disorder ☐ Other: _____

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

☐ Antidepressant	Name:	Dose:	Frequency:
☐ Mood Stabilizer	Name:	Dose:	Frequency:
☐ Stimulant	Name:	Dose:	Frequency:
☐ Anxiolytic	Name:	Dose:	Frequency:
☐ Antipsychotic	Name:	Dose:	Frequency:

☐ 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 relevant information impacting care:** _____

Date Mailed or Faxed to Other Practitioner/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 in Section A to release the information contained on this form to the practitioner/provider listed in section B above. 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**

I do not want to have information shared with:

☐ My PCP/Medical practitioner ☐ I am not currently receiving services from a PCP/ other medical practitioner
☐ My other behavioral health practitioner(s) ☐ I am not currently receiving services from any other behavioral health practitioner

Behavioral Health Practitioner/Facility Representative Signature **Date**

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