Behavioral Health and Primary Care Provider-Coordination of Care Form

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SECTION 1 – CLIENT INFORMATION

Client Name: Date of Birth:

Phone Number: Insurance Name & ID:

SECTION 2 – PRIMARY HEALTHCARE PROVIDER

Provider Name:

Clinic/Practice:

Phone: Fax:

Address:

City: State: ZIP:

SECTION 3 – PURPOSE OF SHARING INFORMATION

Select all that apply:

Coordinate care between mental health and medical providers

Provide updates about treatment

Communicate medication information

Support safety or wellness planning

Request or share treatment summaries or diagnoses

Other:

SECTION 4 – INFORMATION THAT MAY BE EXCHANGED

This authorization allows Daring Minds Therapy and the provider named above to exchange information as needed for treatment, including treatment summaries, diagnosis (if applicable), behavioral or emotional concerns, medication information, health or safety considerations, and treatment-planning information. All information is shared in accordance with HIPAA privacy regulations.

SECTION 5 – CLIENT AUTHORIZATION & RIGHTS

- I may withdraw this authorization at any time by submitting a written request.
- Withdrawal does not apply to information already shared.
- My information cannot be re-released without my permission unless required by law.
- I may decline to sign this form and still receive services.
- This authorization expires in 12 months unless a different end date is listed below
- I have received (or been offered) a copy of this signed form.
- This form has been fully explained to me, and I understand its contents.

Different end date (if desired):
Please select one:

I authorize coordination of care between Daring Minds Therapy and the provider listed above.

I do NOT authorize this exchange.

I do not currently have another provider involved in my care.

Client Signature (18+): Date:

Parent/Guardian Signature (if minor): Date:

Witness Signature: Date: