Continuity and Coordination of Care
Authorization and Release of Information

Communication between and among your **behavioral health care providers**, your **primary care physician** and/or your **pain management providers** is important for you to receive comprehensive and quality healthcare. We are requesting that you authorize and consent to the exchange of health information between your **health care providers** identified below.

_____ _____, _____

Patient First Name Print *Patient Last Name Print* *Patient DOB*

I authorize the **health care providers** identified below to exchange information related to my/child's physical and behavioral health evaluations and treatment plans:

Jill Bracken D.O. Bracken Psychiatric Services	**Phone #:** (972) 278-5385
Address: 3200 Southern Dr. #107 Garland, TX 75043	**Fax #:** (972) 692-8687
www.BrackenMentalHealth.com	admin@brackenmentalhealth.com

Primary Care Provider Name:	**Phone #:**
Address:	**Fax #:**

Pain Management Provider Name:	**Phone #:**
Address:	**Fax #:**

	Phone #:
Address:	**Fax #:**

I, the undersigned, understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance upon it. To revoke this authorization I must send a written request to:

Privacy Officer at Bracken Psychiatric Services 3200 Southern Dr. #107 Garland, TX 75043.

This authorization expires **twelve (12) months** from the date of signature.

This information is being disclosed on the condition that it not be re-disclosed except as authorized or permitted by applicable Federal or State laws, including the Federal Privacy Regulations. I understand that information disclosed pursuant to this authorization may, in some instances, no longer be protected by the Privacy Regulations. Re-disclosure may occur in situations such as if my provider's care is reviewed by a State or Federal agency, a court orders the disclosure of information, or if I sue my provider and my provider needs the information to defend himself/herself.

Please initial to authorize:

☐ I give my authorization to release to, obtain from, and discuss with the identified health care provider(s) the following information**:** Medical information**,** HIV status, Substance abuse information and Behavioral health information, excluding "psychotherapy notes" as defined by HIPAA.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

_____ _____ _____

Printed Name of Patient/Guardian/Representative Signature of Patient/Guardian/Representative Date

_____

Relation to Patient