

**COORDINATION OF CARE**

**Medical Coordination of Care and Release of Health Record:**

To coordinate with your Primary Care Physician {PCP) or Healthcare provider, it is necessary for **La Mente Behavioral Health LLC** to request your per permission to discuss any medical history orders, illness or injury, treatment plan, or diagnosis, etc from your current or past with your medical provider.

You have the right to refuse consent. It will not affect your treatment, Medicaid benefits or payment.

Patient Name: DOB: \_\_\_\_\_\_\_

Please initial below:

 I authorize **La Mente Behavioral Health LLC,** to coordinate and request information such as; (check those that apply}

 Medical

History Doctors Orders

Diagnosis

Labs

 Other \_

From (PCP/Healthcare provider) Name: \_

Address: Phone# Fax# \_ Mail:

**La Mente Behavioral Health LLC**

811 Chelsea Street, Suite B El Paso, TX 79903 Secure **Fax (915) 233-3053**

 I do NOT authorize La Mente Behavioral Health to obtain/coordinate /discuss my past or present medical information with any internal or external providers.

Patient /LAR signature: Date \_\_\_\_\_\_\_\_\_\_\_\_

Witness/staff Name: Signature: Date \_\_\_\_\_\_\_\_\_\_\_\_