The Holman Group
Managed Behavioral Health Care Services

Coordination of Care Form

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PCP AND/OR OTHER HEALTH CARE PRACTITIONERS

I, ______________________________, ________________________________authorize
Member Name— Please print Date of Birth

______________________________, to release health information related to my evaluation
Provider Name—Please Print

and treatment to : ____ ______________________
PCP or other practitioner name— please print phone number

Information to be completed by Behavioral Health Provider

The following treatment is being provided:

_______ Outpatient Therapy Frequency____________

- ☐ Individual Psychotherapy
- ☐ Family Psychotherapy
- ☐ Group Psychotherapy
- ☐ Couples Therapy
- ☐ Other

_______ Medication Management Frequency:_________

Medications and Dosages: ____
____

_______ Intensive Outpatient Frequency_____________________________

_______ Inpatient Treatment

_______ Partial Hospitalization

_______ Residential Treatment

If you have any questions or would like to discuss this case in greater detail, please call me at:
_____________________________.
Phone Number

______________________________ ______________________________ __________________ ________________
Provider Printed Name Provider Signature Provider Licensure Date

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care I may receive. This authorization, becomes effective on the date signed and may be revoked by me at any time in writing, except to the extent action has been taken and reliance hereon.
All parties agree to comply with Protected Health Information pursuant to HIPAA regulations contained in 45CFR Parts 160 and 164. This authorization also authorizes the release of information under the California Confidentiality of Medical Information Act of 1980, Section 56 et.seq. of the California Code.

____ ____________________________________
Signature of Patient or Legal Guardian Date

____
Printed Name of Patient

Send completed form to PCP and/or other practitioner and keep original in treatment record.