

BEHAVIORAL/MENTAL HEALTHCARE COORDINATION FORM

Name of Patient: _____ **Patient ID Number:** _____

Information exchanged for purposes of treatment, payment and healthcare operations is permitted under the Health Insurance Portability and Accountability Act (HIPAA) even without a member's authorization to do so. A member's authorization is required only before behavioral health practitioners share psychotherapy notes (session notes kept separate from the medical record consisting of the contents of conversation during a private, group, joint, or family counseling session) which are not included in this form.

PCP or Other Healthcare Professional Who Is Also Providing Care

Name _____ **Fax #** _____

Address _____ **Phone #** _____

Dear Doctor: _____ **Today's Date:** _____

The above named patient is receiving behavioral health services. **Date of First Session:** _____

Current Diagnosis: _____

Current Psychotropic Medications

MEDICATION	DOSAGE	START DATE	PRESCRIBED BY

Coordination of Care Issues and/or Recommendations

Behavioral Health Practitioner

Name _____ **Fax #** _____

Frankie Sanchez, LCSW, ACAS
Licensed Clinical Social Worker Lic. No. SW13885
Advanced Certified Autism Specialist Cert. No. ACAS165869

Address _____ **Phone #** _____

Signature of Patient/Guardian: _____ **Date:** _____

Patient/Guardian

Name _____ **Date of Birth:** _____

Address _____ **Phone #** _____

Signature of Patient/Guardian: _____ **Date:** _____



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A Place for the Mind to Unwind

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