Dear Practitioner:

The assessment, treatment, and follow-up of a member's care are essential in the provision of continuous and appropriate health care services for members who access multiple practitioners for medical and/or behavioral purposes. The APA Guideline for Treatment of Patients with Major Depressive Disorder, Third Edition states*; "…communication and coordination of treatment are essential. Optimal communication with other health care professionals can improve overall treatment by assuring that medical conditions and psychosocial issues are appropriately addressed. Good communication also decreases the risk that patients will receive inconsistent information about treatment options and risks and benefits. Furthermore, communication among clinicians improves vigilance against relapse, side effects, and risk to self or others."*

Communication between treating providers should be paramount in the following circumstances:

- Members who are prescribed medications by their Primary Care Physician (PCP) and psychiatrist
- PCPs who prescribe psychotropic medications
- R/O thyroid disorders or other medical conditions in members with symptoms of depression. It is recommended that the patients have a complete physical examination that includes a full evaluation and appropriate laboratory studies.
- Members who have an underlying medical condition and are being prescribed psychotropic medication by their psychiatrist
- Members who exhibit a failure to improve
- Members who show a sudden change in mental status

The enclosed document has been developed by Beacon Health Options to facilitate coordination of care between behavioral health providers and PCPs. The first page contains the Authorization for Use or Disclosure and the Notice of Rights for the member and should be kept in the member's chart. The second page is a form that contains basic information to be exchanged and can be faxed or mailed to the PCP or other treating provider.

Sincerely,

Beacon Health Options Quality Management Team

Authorization for the Use or Disclosure of Health Information

Member Name:_____ **Member Date of Birth:**_____

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Member Consent to Exchange Information (to be completed by member)

I,_____, **do** / **do not** authorize _____ my
Name of Member (circle one) Name of Provider

[ ] Primary Care Doctor [ ] Behavioral Health Provider

to exchange information regarding my mental health/substance use treatment and medical health care for continuity of care purposes.

INFORMATION TO WHICH THIS AUTHORIZATION APPLIES

- ❑ All health information pertaining to any medical history, mental or physical condition, and treatment received.
- ❑ Only the following records or types of health information (including any dates):

_____

- ❑ I specifically authorize the release of personal health information relating to drug and/or alcohol use. The recipient of drug and/or alcohol use information disclosed as a result of this authorization will need my further written authorization to re-disclose this information.

NOTICE OF RIGHTS AND OTHER INFORMATION

Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits unless this authorization is necessary to determine your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time; and
- You have a right to receive a copy of this signed authorization.

Permission/authorization to release this information expires one year from the date below.

Patient Signature: _____

Date: __ __ / __ __/ __ __ __ __ Time: _____ am / pm

Signature: _____

Guardian/Parent/Authorized Representative if necessary

Provider Fax Form

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Member Name_____

Member Date of Birth_____

Provider Information (to be completed by behavioral health provider)

Provider Name_____
Address_____
Phone #_____ Fax#_____
Urgent/Emergent # _____

DSM V Diagnosis_____ _____
First date of service_____

Treatment Plan: Type_____ **Frequency**_____
Est. Length of Tx _____
(e.g., Ind, Family, Grp, Meds) (e.g., weekly)
Brief description of issue(s) that prompted treatment:

_____
_____
_____
_____

(If you need to communicate about an urgent or emergency situation, please call the members practitioner in addition to sending form)

- ❑ **Recommend member have a complete physical exam**
- ❑ Conclusion of mental health treatment: Date of last session_____ Treatment completed? Yes___ No___
- ❑ Do you have a follow-up appointment scheduled? Yes___ No___
- ❑ **Notification of prescription or change in medications (details below)**
- ❑ Other:_____

_____
_____
_____
_____
_____
_____
_____

_____

Provider signature