HUMAN AFFAIRS INTERNATIONAL OF CALIFORNIA/MAGELLAN BEHAVIORAL HEALTH
BEHAVIORAL HEALTH AND PRIMARY CARE PHYSICIAN (PCP)
SUMMARY OF CARE FORM

BEHAVIORAL HEALTH PROVIDER INSTRUCTIONS: Please have your patient complete the patient section of this form. Promptly return this form to the attention of the Care Manager with whom you are conducting utilization review. Please retain a copy of this form for your records.

PATIENT SECTION

Patient Name:____ Patient Birth Date:______________ Case #: ___________________________

Patient Address, City, State, Zip:____

Name of Patient's Primary Care Physician (PCP):____

PCP's Address. City, State, Zip:____

Phone #:____ Fax #:____

Name of Behavioral Health Facility/Attending Physician:____

Facility Address, City, State, Zip:____

Phone #:____ Fax #:____

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

I **authorize** the release/exchange of confidential information among my behavioral health provider, Human Affairs International of California, Western Health Advantage and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care. I understand that this consent is automatically renewable each year for so long as I remain in the care of my behavioral care provider and my primary care physician and continue health benefit coverage through Western Health Advantage and Human Affairs International of California. I understand that the confidential information that is exchanged will be kept by the recipient until such time as state law allows destruction of my patient record. I further understand that this authorization may be revoked by me, in writing, at any time, except to the extent that any action has been taken in reliance thereon. I understand that I, and/or my legal representative, am entitled to a copy of this form. I give my permission for release of the following information:

Diagnosis and Treatment ________ (initial) Behavioral Health Information ________ (initial) HIV Status/STD Diseases ________ (initial)

*Patient/Legal Guardian Signature:*____ *Date:*__________

*****Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.**

--OR--

I **refuse** to authorize the release/exchange of any behavioral health and medical information between my behavioral health practitioner and my primary care physician to promote the continuity and coordination of my behavioral health care and my general medical care.

*Patient/Legal Guardian Signature:*____ *Date:*__________

*****Patient/Legal Guardian: Please sign and date ONE of the signature lines. Do NOT sign both lines.**

SUMMARY OF FACILITY BASED CARE

Dear Primary Care Physician: The following information about the patient's behavioral health care may be helpful for you in managing the patient's medical care:

The patient was treated by ________________________________ *(facility name)* **from** ____________________ *(admit date)* **to** ____________________ *(discharge date)* **at the** ____________________ *(level of care)* **level of care. The patient's behavioral health diagnosis is** ____ *(write out DSM-IV diagnosis and code)*.

The patient's plan for continued treatment includes:

Behavioral Health Practitioner Name and Licensure	***Phone Number***	***Date of Follow-up Appointment***

PCP INSTRUCTIONS: Please contact the behavioral health practitioner for continued treatment listed above in the "Summary of Facility Based Care" section to provide any medical information that may relate to this patient's behavioral health care. Examples of information that may relate to a patient's behavioral health care include: current and/or chronic medical conditions, current medications and dosages, sensitivities to medications and/or psychosocial stressors (e.g., loss of job, injuries, financial stress, parenting problems, etc.). Please call 800-424-1565 x7140 if you wish to discuss this patient' care further or if you need additional information. Thank you.

Notice to Recipient of Information: This information has been disclosed to you from records protected by Federal and State laws regarding confidentiality. In accordance with Federal and State laws, the information received pursuant to this document is confidential and the recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2 or the California Confidentiality of Medical Information Act. . A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal law restricts the use of this information to criminally investigate or prosecute members who are being treated for substance abuse.