"THE GREEN FORM" BEHAVIORAL HEALTH SERVICES COMMUNICATION

TO: _____

FROM: _____ **PHONE:** _____

PATIENT NAME: _____ **DOB:** _____ **Gender:** _____

PARENT/LEGAL GUARDIAN: _____

ADDRESS: _____

HOME PHONE: _____ **CELL PHONE:** _____

REFERRAL RATIONALE: _____

_____

_____

CURRENT MEDICATIONS: _____

OTHER MEDICAL DIAGNOSES/CONCERNS: _____

Please FAX/EMAIL BACK TO _____ **at [phone]** _____**, or**

[email] _____

AFTER COMPLETION OF THE SECTION BELOW

TREATING BH PROVIDER: _____ **PHONE:** _____

DATE OF VISIT: _____ **DIAGNOSIS** (if any)**:** _____

TREATMENT PLAN: _____

_____

_____

_____

OTHER RECOMMENDED FOLLOW-UP: _____

_____

_____

_____

FAX/EMAIL BACK TO PEDIATRIC PRIMARY CARE PROVIDER AFTER PATIENT VISIT
(Sample Release of Information authorization on back. Alternatively, use a release of your choice.)

FAX: _____ **EMAIL:** _____

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN®
Hezekiah Beardsley Connecticut Chapter
INCORPORATED IN CONNECTICUT

CONNECTICUT PSYCHOLOGICAL ASSOCIATION

CONNECTICUT ASSOCIATION FOR Infant Mental Health

Connecticut Council of Child and Adolescent Psychiatry, Inc.

Dear Parent/Guardian:

Communication between your child's Behavioral Health Provider (BHP) and Primary Care Physician (PCP) is important to ensure that your child receives comprehensive and quality health care. This form will support your BHP and your PCP to share information about your child. This information is often referred to as 'protected health information' (PHI). Please bring this form with you to any BHP visit. If you are asked to sign this consent by your BHP, please do so. PHI may include diagnosis, treatment plan, progress, lab tests, and medication, as necessary.

Authorization and Consent for Release and Exchange of Confidential Information

Name of Patient: _____

By signing below, the patient and/or his/her/their parent (as applicable) understand that the purpose(s) or need for the exchange and disclosure of this information includes all of the following:

- to facilitate treatment
- to coordinate continuing care

Specifically, the patient and/or his/her/their parent (as applicable) authorize the following information to be disclosed:

- Treatment and medical records, including records that pertain to HIV or sexually transmitted diseases; hospital and discharge records; psychiatric and mental health treatment records; psychological testing records; diagnostic and test results including imaging; admission and registration information; laboratory results; consultations; treatment plans; progress notes; continuing care records; and, billing records.

Statement of the Patient and/or his/her/their parent (as applicable):

I authorize the following healthcare providers to release, disclose, and/or redisclose my health information by and between them as necessary to provide care and treatment, coordinate care, or properly monitor the patient's care and progress:

Primary Care Physician:

_____

Behavioral Health Provider:

_____

I understand that my health information may contain sensitive information, including: confidential HIV (or AIDS) information, psychiatric and/or other mental health records, and I expressly consent to the sharing of this information.

I am not authorizing release of any substance use disorder records, including alcohol and/or drug treatment records, that are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records, 42 CFR Part 2.

I further understand that I have rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR Parts 160 and 164, including that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on this consent. I understand that I may refuse to sign this consent and that my refusal to sign will not jeopardize my right to obtain healthcare treatment except to the extent such disclosure is necessary to provide treatment. I also understand that if the person or entity receiving information about me is not a provider or insurance program that must follow HIPAA, that the information disclosed may no longer be protected by HIPAA.

This authorization shall expire automatically one year following the date signed below.

_____ _____

Signature of Patient Date

If person signing is other than the patient:

_____ _____

Signature of Parent, Date

Guardian or Authorized Representative