Sahara Behavioral Health

CONFIDENTIAL EXCHANGE OF INFORMATION RELEASE FORM

Sahara Behavioral Health is required to coordinate treatment with other behavioral health practitioners and providers, primary care practitioners (PCPs), and other appropriate care provider(s) treating the member.

Fill This Section Only

Treating Behavioral Health Clinician/ Facility Information:

Sahara Behavioral Health 6677 W. Thunderbird Rd. Suite I – 164, Glendale AZ. 85306

Phone: (623) 878 – 2100 Fax: (623) 776 – 9419

Patient Name: ______________________________ DOB____

PCP, medical Clinician Name: _______________________________ Phone/Fax: ________________________________

PCP, medical Clinician Name: _______________________________ Phone/Fax: ________________________________

I hereby freely, voluntarily and without coercion, authorize the Sahara Behavioral Health to release the information contained on this form to the practitioner/ provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

____

Patient Signature **Date**

____

Behavioral Health Clinician/ Facility Representative **Date**

I do not want to have information shared with: ☐ My PCP/ medical practitioner

DATE MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: ______________________________________

Fill This Section Only

For Provider use Only, Do not fill Below This

C. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem(s):

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O
☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O
☐ Personality D/O ☐ Other__________________________________

2. The patient is taking the following prescribed psychotropic medication(s):

☐ Antidepressant-SSRI/SNRI ☐ Antidepressant- Tricyclic ☐ Antidepressant-MAOI ☐ Antidepressant- Wellbutrin
☐ Lithium ☐ Antipsychotic- Atypical ☐ Antipsychotic- Typical ☐ Clozaril
☐ Stimulant ☐ Anxiolytic ☐ Anticonvulsant/ Mood Stabilizer
☐ Other____

3. Expected length of treatment: ☐ <3months ☐ 3-6 months ☐ 6-12 months ☐ >1 year
4. Coordination of care issues/ Other significant information impacting medical or behavioral healthcare:
____
5. ____

For Patient Records Applicable Under Federal Law 42 CFR Part 2

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.