Chapter 503

Behavioral Health Rehabilitation Services

Appendix 503B

Coordination of Care and Release of Information Form

Suboxone®/Subutex®/Vivitrol® Providers

Coordination of Care and Release of Information between Suboxone®/Subutex®/Vivitrol® Provider and BH Provider

Communication between behavioral providers and your Suboxone®/Subutex®/Vivitro®l Prescribing Physician other Behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You have a right to a copy of this signed authorization.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. **This consent expires in one year (12 months) from the date of my signature below unless otherwise stated herein.**

_____ (*BH Provider*) is authorized to release protected health

information related to the evaluation and treatment of _____ (*Member*)

to _____ (*Suboxone®/Subutex®/Vivitrol® Prescribing Physician).*

(Member Name) _____

(Medicaid ID#) _____

Coordination of Care and Release of Information between Suboxone®/Subutex®/Vivitrol® Provider and BH Provider

(Date of Birth – MM/DD/YYYY) _____

Suboxone® or Vitriol® Prescribing Physician:_____

Physician Phone: _____

Physician Address: _____

BH Provider Name: _____

BH Provider Phone:_____

BH Provider Address: _____

Disclosure may include the following verbal or written information: (check all that apply) ___ Demographic Information	___ History & physical	___ Laboratory/diagnostic testing results	___ Other (specify below)
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological Eval/Testing Results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Service Plan
___ Substance abuse treatment record			___ Summary of treatment records, progress notes & contact dates

Coordination of Care and Release of Information between Suboxone®/Subutex®/Vivitrol® Providers and BH Providers

(Print Provider Name) _____

(Signature)_____

(Date)_____

I want to inform you that _____was seen by me for the treatment of: (Member Name)

DSM-IV and/or medical diagnosis:

_____

Date of appointment:

_____

Summary:

The treatment plan consists of the following modalities:

_____ Individual Psychotherapy _____ Group Psychotherapy _____ Family Psychotherapy

_____ Psychological Testing _____Other (specify) _____ Medication Management (see below)

Current Medication(s) (Dosage, Frequency and Delivery)

The following medication was or will be started (indicate medication and dosage):

_____

Estimated length of treatment:

_____

(Print Therapist Name) _____

(Signature)_____

(Date)_____

(Print Member Name) _____

(Signature)_____

(Date)_____

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients. WV Department of Health and Human Resources Bureau for Medical Services.