

HEALTHQUEST, PC

RELEASING INFORMATION TO THE PRIMARY CARE PHYSICIAN

Directions: Please have the patient complete either part A or part B of this form.

Patient's Name: _____

Part A: Agreement to release information to the PCP.

I am allowing HealtQuest, PC to send information (i.e., substance abuse evaluation and/or discharge summary) to my physician, and I have completed a "Release of Information" form.

Patient/Legal Guardian signature

Date

Part B: Decline to release information to the PCP (check the reason the patient is declining.)

_____ I do not have a primary care physician.

_____ I do not want my primary care physician to know about the services I am having.

(name of assessing program)

Patient/Legal Guardian Signature

Date

Primary Care Physician Release

To be completed by patient

Primary Care Physician _____ Phone _____

Address _____ City _____ State _____ ZIP _____

Communication between behavioral health providers and primary care physicians is important to help ensure that all patients receive comprehensive and quality health care. This information is not released without the patients consent. This information may include diagnosis, treatment plan, and medication if necessary.

Below please find the consent or refusal to release said information. The patient may revoke this consent at any time (in writing) except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified.

To be completed by HealthQuest provider:

This patient was seen at our office for mental health treatment as a result of:

- | | |
|---|--|
| <input type="checkbox"/> Direct patient call to our office | <input type="checkbox"/> Post A/D inpatient admission |
| <input type="checkbox"/> Referral from PCP | <input type="checkbox"/> Referral from insurance company |
| <input type="checkbox"/> Post psychiatric inpatient admission | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Current patient at HealthQuest | |

Diagnosis given:

Medications given:

Treatment plan:

- Medication Management
- Referral to _____ for _____
- Other _____

Patient was last seen by me on: _____

_____(Provider)

58 Timber Creek Drive

Cordova, TN 38018

(901) 566-1002

Patient Name: _____ DOB: _____