Coordination of Care Between Providers

Communication between Young Minds Psychiatry LLC and Your Primary care Physician, and other behavioral health provider and/or facilities, is important to ensure you receive compressive and quality health care. This form will allow Young Minds Psychiatry to share protected health information with your other provider. This information will not be released without your signed authorization.

Patient Rights

- You may end this authorization anytime (permission to use or disclose information) by contracting Young Minds Psychiatry and filling out another Coordination of Care form.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or service will be not affected.

Patient Authorization

I hereby authorize that Young Minds Psychiatry, can release verbally or in writing information regarding any 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 law governing the confidentiality of mental health and understand that I may revoke this consent at any time and must do so in writing by filling out a new form. A request to revoke this authorization will not affect any actions taken the provider receive the request. This consent expires in six months from the date of signature below unless otherwise stated herein.

Young Minds Psychiatry LLC is authorization to release protected health information related to the evaluation

and treatment of _____ _____/_____/_____

Patient Name — Date of birth - mm/dd/yyy

_____ _____

Primary Care Physician Name — Primary Care Physician Number

_____ _____ _____

Primary Care Address — City — State

_____ _____

Behavioral Health Name — Behavioral Health Number

_____ _____ _____

Behavioral Health Address — City — State

Disclosure may include following verbal or written information: (check all that apply)

_____ Face sheet
_____ History and physical
_____Laboratory/test results
_____School Information
_____Discharge summary
_____Medical Records
_____Behavioral health
_____Psychological evaluation
_____ER Record report
_____ Psychiatric Evaluation
_____Summary abuse treatment
_____Summary of treatment records and contact dates

_____ **I here refuse to give authorization for any release of information.**

_____ _____

Signature of patient, parent, guardian or authorized representative — Date