RIVERTOWN PEDIATRICS

Authorization for Release of Behavioral Health Information

For Care Coordination & Continuity of Care

This authorization permits the behavioral health provider listed below to disclose the minimum necessary information to Rivertown Pediatrics for coordination of the patient's medical care. **Psychotherapy notes are not requested unless specifically authorized below.**

PATIENT INFORMATION

Patient Name		Date of Birth	
Parent/Guardian		Phone	

AUTHORIZATION

I authorize the behavioral health provider identified above to release records to Rivertown Pediatrics for referral coordination, continuity of care, medication management, diagnosis, and treatment planning.

RECORDS REQUESTED

☐ Psychiatric Evaluation
☐ Diagnostic Assessment
☐ Consultation Reports
☐ Behavioral Health Progress Notes*
☐ Treatment Plan
☐ Medication History / Medication Management
☐ Psychological / Neuropsychological Testing
☐ Behavioral Health Hospital Discharge Summary
☐ Relevant Laboratory Results
☐ Other: _____

***Psychotherapy notes are not requested unless separately authorized.**

SPECIAL AUTHORIZATIONS

Initial only if applicable:
_____ Substance Use Disorder (42 CFR Part 2)
_____ HIV/AIDS-related information (where applicable)
_____ Genetic testing information

☐ I specifically authorize release of psychotherapy notes.

PURPOSE • EXPIRATION • SIGNATURE

Purpose: ☐ Care Coordination ☐ Medication Management
☐ Continuity of Treatment ☐ Pediatric Medical Care

Expiration: ☐ Completion of treatment with provider
☐ One year
☐ Other _____

Patient Rights: I understand I may revoke this authorization in writing at any time except to the extent action has already been taken. A copy or fax of this authorization is as valid as the original.

Parent/Guardian (Print): _____ Relationship: _____

Signature: _____ Date: ___/___/_____

RIVERTOWN PEDIATRICS OFFICE USE

Date Faxed: _____ Date Requested: _____ Date Received: _____ Staff Initials: _____