THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

OSU & HARDING BEHAVIORAL HEALTHCARE & MEDICINE

Primary Care Physician – Patient Care Communication Form

Primary Care Physician Information

| | | | |
|---|---|---|---|
| Dr's Name: | | | |
| | | | |
| Address: | | | |
| City: | | | |
| State: | | Zip: | |
| Phone: | | | |
| Fax: | | | |

Behavioral Health Clinician Information

| | | | |
|---|---|---|---|
| Name: | OSU & Harding Outpatient Services | | |
| | | | |
| Address: | 1670 Upham Drive, 5th Floor | | |
| City: | Columbus | | |
| State: | OH | Zip: 43210 | |
| Phone: | 614-293-9600 | | |
| Fax: | | | |

☐ Patient does not have a Primary Care Physician

AUTHORIZATION TO DISCLOSE INFORMATION

| Patient Name (please print) | Date of Birth: |
|---|---|

I understand that records or information about my mental health, general health, or chemical dependency treatment are confidential; they are protected by applicable state and federal laws, and cannot be disclosed or re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV, and AIDS-Related Complex and the performance of any tests, counseling, and the results and treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 180 days from the date signed.

Patient: Please check one option below.

□ I do authorize any information on my care to be shared between the providers listed above to facilitate my treatment.
□ I do authorize information on my care be shared with the following limitations (check any):
  □ Medications only □ Other _____
□ I do not authorize any information on my care to be shared between by behavioral health clinician and my primary care physician.

_____ _____
Signature of patient or guardian Date

Behavioral Health Clinician: To be filled out by clinician if authorized

| | | |
|---|---|---|
| Presenting Problem/Chief Complaint/Diagnosis: | | |
| Treatment Plan / Recommendations: | | |
| Current Psychotropic Medications: | | |
| Signature: | Phone | Date: |
| Please feel free to contact me if you have information that you believe would be beneficial to our combined care of this patient | | |

Rev: 7/10/13