Coordination of Health Care and Release of Information Form

The coordination of care among treating providers is essential for safe and effective care. To share information regarding your TrueCare patient's care, please complete applicable sections of this document and include signed consent for releasing information, as appropriate.

		Date:
Patient Name:		Date of Birth:
TrueCare Member ID:		
Parent/Guardian Name and Contact Information:		
Primary Care Provider:	Specialist Provider:	Behavioral Health Provider:
Address:	Address:	Address:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:
Additional Contacts (case workers, etc.):		

Patient's active diagnoses (or attach list):

The member is engaged in the following interventions (include frequency): ☐Psychotherapy ☐Medication Management ☐Member Refused Medication ☐ Other (specify):

Frequency of intervention(s):

Most recent hospitalizations (include hospital, dates of stay, and diagnosis):

Reason for referral (coordination of care issues or other significant information affecting physical or behavioral health):

Lab tests: ☐ Complete Blood Count (CBC) ☐ Thyroid Studies ☐ Electrocardiogram (EKG) ☐ Lipid Profile ☐ Serum drug level (specify drug):

Current medications (or attach list):

Adherence to medications: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Adherence to appointments/treatments: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Response to treatment: ☐ Improving with treatment ☐ Stable with treatment ☐ Not improving ☐ No information

Reason for referral – Coordination of care issues or other significant information affecting physical or behavioral health care:

_____

_____

_____

_____

Provider signature: _____

Date: _____

TrueCare has Care Managers available to assist with coordination of care. Please return a copy of this form via fax to **1-937-396-3674** or email MSTrueCareCM@MSTrueCare.com, and a Care Manager will assist with care coordination efforts.

Patient consent – Please check if you DO NOT want the following protected health information released:
☐ Behavioral Health ☐ Substance Use ☐ HIV/AIDS

This authorization will expire one year from today, on _____. I authorize the use and/or disclosure of my protected health information as described here. I understand my signature on this form confirms my wish to release protected health information to the healthcare providers named. I understand that I may revoke this authorization at any time by giving written notice to the person or organization listed above. Refusal to sign this form will not affect my health care provided by (name of provider).

_____

Patient signature: _____

Date: _____

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