

COORDINATION OF TREATMENT FORM

Member Name _____

Member DOB _____

Member's Hoosier Healthwise Number _____

Date of Initial Appt _____

Please initial if you **DO NOT** want the following protected health information released Behavioral Health Substance Abuse

I authorize the use and/or disclosure of my protected health information as described below. I understand that this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke the authorization at any time by giving written notice to that person or organization that is authorized below to release information. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected. I understand that any health care provided by the primary care physician listed below will not be affected if I do not release information.

Signature of client or guardian

Date

Provider Listed Below Will Release Information

Provider Name _____

Facility Name: Vision Counseling & Psych Services

Address: 3948D New Vision Drive

C/S/Z: Fort Wayne, IN 46845

Phone Number: 260-387-6340

Fax Number: 260-387-6984

Info Will Be Released to Physician Listed Below Only

(must be completed in full by member)

Physician Name _____

Facility Name _____

Address _____

C/S/Z _____

Phone Number _____

Fax Number _____

CLINICAL INFORMATION

Diagnosis Code _____

Focus of Behavioral Health Treatment _____

Medications Prescribed: NA

Labs/Tests ordered: NA