Dayton Behavioral Care
627 S. Edwin C. Moses Blvd. Suite 2C, Dayton Ohio-45417
Phone : (937)281-0900 Fax : (937)938-9751

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

PATIENT NAME: _____ DOB: _____

A. Treating Behavioral Health Clinician/ facility

Name: Dayton Behavioral Care

Phone: (937)281-0900

Fax: (937)938-9751

Address: 627, S. Edwin C. Moses Blvd., Ste -2C
Dayton, OH-45417

B. PCP/ Other Medical Practitioner

Name: _____

Phone: _____

Fax:_____

Address: _____

I hereby **authorize/ decline (CIRCLE ONE)** the behavioral health Practitioner listed above in Section A to release the information contained in this form to the practitioner/Provider listed in Section B above. The reason for the disclosure is to facilitate continuity and coordination of treatment. This will last one year from the date signed. I understand that I may revoke my consent at any time.

_____ _____

Patient/ Patient's Guardian Signature Date

C. Patient Clinical Information:

The patient is being treated for _____

_____

And is prescribed psychotropic medication(s) _____

_____

_____

Coordination of care issues/ Other relevant information impacting care: _____

_____

_____ _____

For Patient Records Applicable Under Federal Law 42 CFR Part 2 To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

THIS IS NOT A REQUEST FOR MEDICAL RECORDS

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Behavioral Health Practitioner Signature Date