



# Healthy San Diego

## Physical and Mental Health Care Coordination Form

### MEDI-CAL MANAGED CARE AND CMS PROGRAMS

The use of this form will enhance coordination of care between physical and mental health providers. The form can be initiated by the physical or mental health provider. *The reverse of this form contains an Authorization for Release of Information which must be completed by the client/patient prior to any information being transmitted between providers.*

#### SECTION 1: Client / Patient Information

Date: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Health Plan: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Medi-Cal / CMS # \_\_\_\_\_ SSN / CIN # \_\_\_\_\_

#### SECTION 2: Primary Care Provider Information

Date: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_ Medical Group: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Significant medical condition(s) of client / patient named above: \_\_\_\_\_

Current Medications: \_\_\_\_\_

#### SECTION 3: Mental Health Provider Information

Date: \_\_\_\_\_

Mental Health Practitioner Name: \_\_\_\_\_ Organization: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Current Medications: \_\_\_\_\_

**Authorization for Release of Information or Records**

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_  
 (name of client/patient) (name of physical health provider)  
 and / or \_\_\_\_\_ to share information and records obtained in  
 (name of mental health provider)

the course of my diagnosis and treatment, including substance abuse information, as is necessary for the purpose of coordination of my overall health care. Such disclosure shall be limited to the following specific types of information:

- |                          |                                |
|--------------------------|--------------------------------|
| _____ Diagnosis          | _____ Psychological Evaluation |
| _____ Current Medication | _____ Psychiatric Assessment   |
| _____ Medication Records | _____ Consultation Reports     |
| _____ Physicians Orders  | _____ Treatment / Service Plan |
| _____ Lab Reports        | _____ Discharge Plan           |
| _____ Discharge Summary  | _____ Other                    |
| _____ History & Physical | _____                          |
| _____ Progress Notes     | _____                          |

I understand that I may revoke this authorization at any time.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_

\_\_\_\_ Initials of person providing a copy of this authorization to the client / patient.

**If you need to reach a plan representative, please call:**

Blue Cross of California	(800) 407-4627	UCSD Health Plan	(800) 688-6161
Community Health Group	(800) 404-3332	Universal Care	(800) 635-6668
Health Net	(800) 675-6110	County Medical Services	(858) 495-1300
Kaiser Permanente	(619) 641-4939	United Behavioral Health	(800) 479-3339
Sharp Health Plan Sharp Advantage	(800) 359-2002		

For more copies of this form, go to [www.ubhpublicsector.com](http://www.ubhpublicsector.com).

COUNTY OF SAN DIEGO HEALTH AND HUMAN SERVICES AGENCY