

## **APPENDIX G**

### **Primary Care Physician (PCP) Communication Information**





(CIGNA cannot provide you with legal advise on the use of any release form for your practice. The following is a sample only. You should obtain the advice of legal counsel for your practice).

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO PRIMARY CARE PHYSICIAN

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ all clinical information about me as may be necessary to permit my Primary Care Physician to monitor the continuity of my care and to inform my Primary Care Physician of my health status.

This authorization becomes effective \_\_\_\_\_, and may be revoked by me in writing at any time, with the exception of any actions already taken to coordinate my care. Unless previously revoked by me, this authorization automatically terminates the earlier of six (6) months from the effective date. I understand that this authorization does not extend to the release of any AIDS/ HIV information unless I also placed my initials here \_\_\_\_\_. I further understand that the information authorized by this release will be released to the authorized representative only, for purposes noted above. I understand I (or my legal representative) am entitled to a copy of this authorization form for my records.

Legal Signature of Participant or Legal Guardian

Date

Name of Participant

Witness

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and State law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.



**DRAFT LETTER FOR PRACTITIONERS' COMMUNICATIONS WITH  
PRIMARY CARE PHYSICIANS**

Date \_\_\_\_\_

Primary Care Physician Name  
Primary Care Physician Address  
City, State and Zip Code

Re: Participant's Name

Dear Dr. \_\_\_\_\_:

Your patient, \_\_\_\_\_ has identified you as their primary care physician. In my work with Mr./Mrs./Ms \_\_\_\_\_ we have discussed the importance of coordinating an individual's total health care across health care professionals. In response to this discussion, \_\_\_\_\_ has given his/her consent for me to contact you, introduce myself as his/her behavioral health care practitioner and work directly with you when necessary.

At the present time \_\_\_\_\_ has been in care with me since \_\_\_\_\_. In my continued work with \_\_\_\_\_ I will be in touch with you as changes occur which would be pertinent to our coordination efforts.

As \_\_\_\_\_'s overall health care is of primary importance, I will be available to you and can be reached at \_\_\_\_\_. I look forward to our working together on an integrated approach for an optimal treatment outcome.

Respectfully,

CIGNA

cc: Participant



## BEHAVIORAL HEALTH PRACTITIONER/FACILITY TO PRIMARY CARE PHYSICIAN COMMUNICATION FORM

Participant Name \_\_\_\_\_ Participant ID # \_\_\_\_\_ Participant Date of Birth \_\_\_\_\_

TO: \_\_\_\_\_ FROM: \_\_\_\_\_  
 Contact \_\_\_\_\_ Contact \_\_\_\_\_  
 Phone \_\_\_\_\_ Phone \_\_\_\_\_  
 Fax \_\_\_\_\_ Fax \_\_\_\_\_  
 Release of Information Obtained: Yes No Address: \_\_\_\_\_  
 \_\_\_\_\_

Date Admission or Treatment Began \_\_\_\_\_ Date Facility Discharge or Last Seen \_\_\_\_\_

<b>Behavioral Diagnosis or Condition</b> (note if Initial or Final)	
(Mental Health/Substance Use)	
<b>Treatment Recommendations</b> (note if Planned or Completed)	
<b>Ancillary Tests / Evaluations / Findings</b>	
<b>Behavioral Prescriptions and Dosages</b>	
<b>Outcome of Treatment</b>	
<b>Degree of problem resolution</b>	<b>Indications for re-referral</b>
<b>Discharge medications</b>	<b>Follow-up recommendations</b>
<b>Clinical Issues</b> (e.g. compliance, stability, medication issues, co-morbid conditions)	