

**New Orleans Center for Mind-Body Health**  
**643 Magazine St. Suite 304**  
**New Orleans, Louisiana 70130**  
**(O)504.355.0509 (F)504.355.0508**

**Coordination of Care between Health Care Providers and Release of Information**

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

**Patient Rights**

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

**Patient Authorization**

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

**NOCMBH Providers and other Healthcare Providers (Specify Names, Phones and Faxes):**

\_\_\_\_\_  
\_\_\_\_\_

are authorized to release protected health information to each other in regards to the evaluation

and treatment of \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_.  
(Member Name) (Member ID#) (Date of Birth – MM/DD/YYYY)

Disclosure may include the following verbal or written information:  
Face sheet History & physical Laboratory/diagnostic testing results School information  
Discharge summary Medication records Behavioral health/psychological consult Psychological eval/testing results ER record report  
Psychiatric evaluation Psychosocial assessment Other  
Substance abuse treatment record Summary of treatment records & contact dates

\_\_\_\_\_  
(Signature of Patient, Parent, Guardian or Authorized Representative) (Date)