CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Optum requires contracted behavioral health practitioners and facilities to coordinate treatment with other behavioral health practitioners, primary care physicians (PCP), and other appropriate medical practitioners involved in a member's care. Please complete this form and send it to the appropriate care provider(s) treating the member via a HIPAA compliant method.

PATIENT NAME: _____ **DOB:** _____

A. Treating Behavioral Health Clinician/Facility Information:

Name: Phone:

Address: Secure Fax/Secure Email:

☐ I am not currently receiving services from a PCP/Other medical Practitioner
☐ I am not currently receiving services from any other Behavioral Health Practitioner

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Facility Information:

Name: Phone:

Address: Secure Fax/Secure Email:

☐ Denies current services from a PCP/Other Medical Practitioner
☐ Denies current services from other Behavioral Health Practitioner/Facility

C. Patient Clinical Information:

1. **The patient is being treated for the following behavioral health condition(s):**

☐ ADHD/ Behavior Disorder ☐ Substance Use Disorder ☐ Psychotic Disorder ☐ Bipolar Disorder
☐ Depressive Disorder ☐ Anxiety Disorder ☐ Eating Disorder ☐ Adjustment Disorder
☐ Personality Disorder ☐ Other: _____

2. **The patient is taking the following prescribed psychotropic medication(s):**

Medication Name	Dosage	Frequency	Purpose	Prescribed By

Additional medications patient reports taking:_____ Prescribed by:_____

3. **Treatment Start Date:** _____ **Expected length of treatment**: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. **Treatment being provided:** ☐ Psychotherapy ☐ Medication Management Other: _____

5. **Coordination of care issues/Other relevant information impacting care:** _____

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. I further understand that by signing below, I am

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authorizing the release or exchange of these records to the parties named above. The reason for disclosure is to facilitate continuity and coordination of treatment.

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information.

This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

_____ _____

Patient Signature **Date**

☐ **MEMBER DECLINED TO ALLOW COORDINATION OF CARE**

_____ _____

Behavioral Health Practitioner/Facility Representative Signature **Date**

Date Mailed or Faxed to Other Practitioner/Facility: _____ ☐ **Please provide treatment summary in return**

(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

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

Nondiscrimination Notice and Access to Communication Services

Optum companies (together, "Optum") provide services to health plans and other health programs or activities. Optum does not exclude people or treat them unfairly because of sex, age, race, color, national origin, or disability.

Free services are available to help you communicate with us and with your health plan. Such as, letters in other languages, or in other formats such as large print. OR, you can ask for an interpreter. To ask for help, please call the toll-free number on your member ID card. TTY 711.

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Optum Civil Rights Coordinator
11000 Optum Circle
Eden Prairie, MN 55344
Fax: 1-855-351-5495
Email: optum_civil_rights@optum.com

If you need help with your complaint, please call the toll-free number on your member ID card. TTY 711. You must send the complaint within 60 days of when you found out about the issue.

You can also file a complaint with the U.S. Department of Health and Human Services:

Online: ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at:hhs.gov/ocr/office/file/index.html
Phone: Toll-free **1-800-368-1019, 1-800-537-7697** (TDD)
Mail: U.S. Dept. of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

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Language Assistance Services & Alternate Formats

This information is available in other formats like large print. To ask for another format, please call the toll-free number on your member ID card. TTY 711.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call the toll-free phone number listed on your identification card.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al número de teléfono gratuito que aparece en su tarjeta de identificación.

請注意：如果您說中文**(Chinese)**，我們免費為您提供語言協助服務。請撥打會員卡所列的免付費會員電話號碼。

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi số điện thoại miễn phí ở mặt sau thẻ hội viên của quý vị.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 신분증 카드에 기재된 무료 회원 전화번호로 문의하십시오.

PAALALA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Pakitawagan ang toll-free na numero ng telepono na nasa iyong identification card.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по бесплатному номеру телефона, указанному на вашей идентификационной карте.

تنبيه: إذا كنت تتحدث **العربية (Arabic)**، فإن خدمات المساعدة اللغوية المجانية متاحة لك. الرجاء الاتصال على رقم الهاتف المجاني الموجود على معرّف العضوية.

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nimewo gratis ki sou kat idantifikasyon w.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro de téléphone gratuit figurant sur votre carte d'identification.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod bezpłatny numer telefonu podany na karcie identyfikacyjnej.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue gratuitamente para o número encontrado no seu cartão de identificação.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Per favore chiamate il numero di telefono verde indicato sulla vostra tessera identificativa.

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ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte rufen Sie die gebührenfreie Rufnummer auf der Rückseite Ihres Mitgliedsausweises an.

注意事項：日本語**(Japanese)**を話される場合、無料の言語支援サービスをご利用いただけます。健康保険証に記載されているフリーダイヤルにお電話ください。

توجه: اگر زبان شما **فارسی (Farsi)** است، خدمات امداد زبانی به طور رایگان در اختیار شما می باشد. لطفا با شماره تلفن رایگانی که روی کارت شناسایی شما قید شده تماس بگیرید.

यान द: यिद आप **िहदं ी (Hindi)** बोलते है, आपको भाषा सहायता सेबाएं, िन:शकु उपल ध ह। कृपया अपने पहचान पत्र पर सचीबद्ध टोल-फ्री फोन नंबर पर कॉल कर।

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau tus xov tooj hu deb dawb uas teev muaj nyob rau ntawm koj daim yuaj cim qhia tus kheej.

ចណាំប់អារមមណ៍: េបើសិនអនកនិយាយភាសាែខមរ**(Khmer)**េសវាជំនយួភាសាេដាយឥតគិតៃថល គមា ឺនសំរាប់អកន ។ សមួ ទូរស័ពេទ ទៅេលខឥតគតិ ៃថល ែដលមានេនៅេលើអតសដញ្ញាញ ណប័ណារបស់អកន ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti toll-free a numero ti telepono nga nakalista ayan iti identification card mo.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yáníłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shǫǫdí ninaaltsoos nitł'izí bee nééhozinígíí bine'dęę' t'áá jíík'ehgo béésh bee hane'í biká'ígíí bee hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac lambarka telefonka khadka bilaashka ee ku yaalla kaarkaaga aqoonsiga.

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