The following sample forms are tools intended to help facilitate communication between providers and may serve as a model for the exchange of clinical information between Behavioral Health and Primary Care Providers. Cigna-HealthSpring believes that through communication and coordination of care, disruptions and delays in treatment may be prevented and poor health outcomes averted.
(Cigna-HealthSpring Health cannot provide you with legal advice 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 _____________________
Member’s Name         Practitioner’s Name
to disclose to my Primary Care Physician, ________________________ 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
SAMPLE LETTER FOR BEHAVIORAL HEALTH 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,

Behavioral Health Provider's name
# Behavioral Health Practitioner/Facility to Primary Care Physician Communication Form

<table>
<thead>
<tr>
<th>Participant Name</th>
<th>Participant ID #</th>
<th>Participant Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO:</td>
<td>FROM:</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Contact</td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td>Phone</td>
<td></td>
</tr>
<tr>
<td>Fax</td>
<td>Fax</td>
<td></td>
</tr>
<tr>
<td>Release of Information Obtained: Yes No</td>
<td>Address: __________________________</td>
<td></td>
</tr>
<tr>
<td>Date Admission or Treatment Began</td>
<td>Date Facility Discharge or Last Seen</td>
<td></td>
</tr>
</tbody>
</table>

**Behavioral Diagnosis or Condition** *(note if Initial or Final)*

**Mental Health/Substance Use**

**Treatment Recommendations** *(note if Planned or Completed)*

**Ancillary Tests / Evaluations / Findings**

**Behavioral Prescriptions and Dosages**

**Outcome of Treatment**

<table>
<thead>
<tr>
<th>Degree of problem resolution</th>
<th>Indications for re-referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge medications</td>
<td>Follow-up recommendations</td>
</tr>
</tbody>
</table>

**Clinical Issues** *(e.g. compliance, stability, medication issues, co-morbid conditions)*