HURLEY MENTAL HEALTH ASSOCIATES

Notice of Involvement with Behavioral Health Provider

All other providers, please fax or send most recent lab results, physical & medication list (FAX 810-230-3376)

Patient Name: _____ ***DOB:*** _____

I, _____ ***DO*** *or* ***DO NOT*** *authorize Hurley Mental Health Associates, my behavioral health provider & my*
(Please print name) *(circle one)*

Primary Care Physician, _____*,Address:* _____

City: _____*State:* _____*Zip:* _____*telephone #* _____ *to exchange information regarding my mental health/substance abuse treatment and medical healthcare; for the purpose of coordination of care, including as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health care or substance abuse care and/or treatment (as protected under 42CFR Part 2) such as diagnosis and treatment plan and medical information, including information regarding the presence or absence of HIV/AIDS. I understand that this authorization shall remain in effect for one year, or the course of treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to HMHA. I also understand that it is my responsibility to notify this provider if I choose to change my Primary Care Physician.*

_____ _____
Signature of patient *Date*

_____ _____
Signature of parent or guardian if patient is a minor *Date*

_____ _____
Clinician Signature *Date*

If patient declined consent to speak with PCP, by initialing here the clinician verifies that he/she has discussed with the patient the need for care coordination to serve the patient's best interests. _____

Revised 3-12-20