GENERAL PSYCHOLOGICAL ASSOCIATES
3 Dundee Park, Suite 203/Andover, MA. 01810
978-475-3590 (Fax) 978-475-7620

CONFIDENTIAL EXCHANGE OF INFORMATION FORM

General Psychological Associates requires all clients to be given this form for the purpose of coordinating treatment with other behavioral health clinicians, PCP's and other appropriate medical practitioners involved in a client's care. Please complete this form and send the original to the appropriate care provider(s) who may be treating the client.

A copy of this form must always be kept in the client's medical record.

PATIENT NAME: DOB:

A. Treating Behavioral Health Clinician/Facility Information:

Name: Phone: 978 475-3590

Address: 3 Dundee Park, Suite 203, Andover, MA 01810

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

Name: Phone:

Address:

Fax:

C. Patient Clinical Information:

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

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O
☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O
☐ Personality D/O ☐ OTHER: _____

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

☐ Antidepressant-SSRI ☐ Antidepressant-Tricyclic ☐ Antidepressant-MAOI ☐ Antidepressant-Wellbutrin
☐ Lithium ☐ Antipsychotic-Atypical ☐ Antipsychotic-Typical ☐ Clozaril
☐ Stimulant ☐ Anxiolytic ☐ Anticonvulsant/Mood Stabilizer
☐ Other (Indicate medication name):

_____

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

4. **Coordination of care issues/Other significant information impacting medical or behavioral health care:**

_____

_____

DATE MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____
(PLACE A COMPLETED COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD)

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. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last one year from the date signed. I understand that I may revoke my consent at any time.

_____
Patient Signature **Date**

_____
Behavioral Health Clinician/Facility Representative Signature **Date**

I do not want to have information shared with:
☐ My PCP/medical practitioner. ☐ My other behavioral health practitioner(s)/provider(s).
☐ I am not currently receiving services from a PCP/ other medical practitioner.
☐ I am not currently receiving services from any other behavioral health practitioner/provider.

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.