

Exchange of Information Form

Patient Name: _____ Date of Birth: ____-____-____

Treating Facility Information

PRA Behavioral LLC
1701 East Woodfield Road
Suite 1000
Schaumburg, IL 60173

Phone: 847-240-2211
Fax: 847-240-2418

PCP/Medical or Behavioral Health Clinician/Facility/Information

This section to be completed by the patient

Name: _____

Address: _____

Phone: _____ Fax: _____

Patient Clinical Information

This Section to be filled out by Clinician/Facility

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

- ADHD/Behavior Disorder Substance Abuse Psychotic Disorder Adjustment Disorder
 Mood Disorder Anxiety Disorder Eating Disorder
 Other: _____

2. The patient is taking the following prescribed psychotropic medication/s:

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 healthcare:

I hereby freely, voluntarily and without coercion, authorize PRA Behavioral LLC to release the information contained on this form to the clinician/facility listed above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will expire 30 days from the date signed. I understand I may revoke my consent at any time.

Patient Signature

Date

Behavioral Health Clinician/Facility Signature

Date

THIS IS NOT A REQUEST FOR MEDICAL RECORDS