EXCHANGE OF INFORMATION FORM

Patient to Complete:

PATIENT NAME: _____ **DATE OF BIRTH:** _____-_____-_____

A. YOUR PRIMARY CARE PHYSICIAN (PCP)

Your PCP's Name:		**PCP's Phone #:**	
PCP's Address:	City:	State:	Zip:
PCP's Fax #:			

I hereby freely, voluntarily and without coercion, authorize the behavioral health clinician/ facility listed below in Section B to release the information contained on this form to the clinician/facility listed in section A above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last 30 days from the date signed. I understand that I may revoke my consent at any time.

_____ _____ _____

Patient Signature (if 12 and older) **Parent/Guardian Signature** **Date**

Provider to Complete:

B. TREATING BEHAVIORAL HEALTH CLINICIAN/FACILITY

☐ Schaumburg Office –PRA Behavioral LLC	☐ Vernon Hills – PRA Behavioral LLC	☐ Crystal Lake – PRA Behavioral LLC
1701 E. Woodfield Road, Suite 1000	3 Hawthorn Parkway, Suite 150	350 Congress Parkway, Suite C
Schaumburg, IL 60173	Vernon Hills, IL 60061	Crystal Lake, IL 60014
Phone: 847-240-2211 Fax: 847-240-2418	Phone: 847-918-8282 Fax: 847-918-8215	Phone: 815-356-5050 Fax: 815-356-5094

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
☐ Mood Disorder ☐ OTHER: _____

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

_____

3. **Outpatient care:**

☐ Medication Management ☐ Individual Therapy ☐ Family Therapy ☐ Other:_____

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

5. **Coordination of care issues/Other significant information impacting medical or behavioral healthcare:**

_____
_____

_____

Behavioral Health Clinician **Date**

DATE FORM MAILED OR FAXED TO OTHER CLINICIAN/FACILITY: _____

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

THIS IS NOT A REQUEST FOR MEDICAL RECORDS