Coordination of Care and Release of Information Form

The coordination of care among treating providers is essential for safe and effective care. To share information regarding your CareSource patient's care, please complete applicable sections of this document and include signed consent for releasing information, as appropriate.

		Date:
Patient name:		Date of Birth:
CareSource Member ID:		
Parent/Guardian name and contact information:		
Primary Health Care Provider	**Specialist Provider**	**Behavioral Healthcare Provider**
Address:	Address:	Address:
Phone:	Phone:	Phone:
Fax:	Fax:	Fax:
Email:	Email:	Email:
Additional Contacts (case workers, etc.):		

Reason for referral (coordination of care issues, or other significant information affecting physical or behavioral health):

_____

_____

Patient's Active Diagnoses (or attach list):

_____

_____

The member is engaged in the following interventions (include frequency): ☐Psychotherapy ☐Medication Management ☐Member Refused Medication ☐ other (specify)

_____

Frequency of intervention(s):

_____

Most recent hospitalizations (include hospital, dates of stay, and diagnosis):

_____

Lab Tests: ☐ CBC ☐ Thyroid Studies ☐ EKG ☐ Lipid Profile ☐ Serum drug level (specify drug)

_____

Current Medications (or attach list):

_____

_____

Adherence to Medications: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Adherence to Appointments/Treatments: ☐ Most of the time ☐ Half of the time ☐ Less than half ☐ Never ☐ No information

Response to Treatment: ☐ Improving with treatment ☐ Stable with treatment ☐ Not improving ☐ No information

Additional comments: _____

_____

Provider signature: _____Date: _____

CareSource has Case Managers available to assist with coordination of care. Please return a copy of this form to CMReferrals_KY_WV@caresource.com or call 1-844-438-9498 and a Case Manager will assist with care coordination efforts.

Patient Consent Please check if you DO NOT want the following protected health information released:
☐ Behavioral Health ☐ Substance Abuse ☐ HIV/AIDS

This authorization will expire one year from today, on _____. I authorize the use and/or disclosure of my protected health information as described here. I understand my signature on this form confirms my wish to release protected health information to the healthcare providers named. I understand that I may revoke this authorization at any time by giving written notice to the person or organization listed above. Refusal to sign this form will not affect my health care provided by _____ (insert name of health care provider).

Patient Signature: _____ Date: _____

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