



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 North Carolina Co. 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 North Carolina Co. 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 North Carolina Co. has Case Managers available to assist with coordination of care. Please return a copy of this form to NC_CM_Team@CareSource.com or call 1-833-230-2046 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: _____

NC-EXC-P-1802103

Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource