truehealth new mexico

Coordination of Care Form

Patients: With your permission, this information will be forwarded to your healthcare provider.

Practitioner/Provider Information		Patient Information
Provider Name		Patient Name
Contact Person for Provider		Patient ID Number/Social Security Number
Phone	Fax	Patient Date of Birth

Patient's Release of Personal Health Information (PHI)	
From (Provider Name)	To (Provider Name)
Member's Signature	Date of Member's Signature

Expiration: I understand that I may cancel this authorization at any time by sending my healthcare provider(s) my cancellation notice in writing. I understand that my healthcare provider(s) may have already released records according to this authorization, prior to receiving my written notice to cancel. Unless cancelled, this authorization expires on (date) _____.

If Member Does Not Authorize Release of PHI	
I **do not** authorize information about my physical and/or behavioral health treatment to be released.	
Member's Signature	Date of Member's Signature

You are not required to share this information. Please check this box if the reason you are not releasing information is because you do not have a primary care provider: ☐ Thank you.

Information to Be Released

The only information this Coordination of Care Form authorizes for release is this one-page Notification of Treatment, including the information below. No additional records will be released without a signed Authorization for Release of Information.

Healthcare Coordination Information	Medications, If Known	Dosages
Treatment Start Date:	1.	
	2.	
Medication Managed by:	3.	
	4.	
ICD-10-CM:	5.	
	6.	
Treatment Plan:		

Confidential Protected Health Information (PHI) enclosed*. PHI is personal and sensitive information related to a person's healthcare. It is being delivered to you after appropriate authorization from the patient/member or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure without additional patient/member consent or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state law.*

FORM INSTRUCTIONS: FAX THIS FORM TO THE PATIENT'S CLINICIAN FOR INCLUSION IN THE PATIENT'S MEDICAL RECORD.