INOVA

1BROI

Emergency Contact (required for every Inova patient)

Emergency Contact Name	Phone Number(s)	Relationship to Patient

Care Coordination At Inova Behavioral Health, our goal is to develop a supportive team approach to your care. Care team members include healthcare providers, family members and other individuals you choose, with whom you have already established a relationship. Please identify below those providers involved in your care and other individuals who may be contacted.

NOTE: Do not include CATS provider information this form. The release of CATS information requires a separate authorization.

	Your Care Team	Name (include organization name, if applicable)	Phone(s)	Address (if unknown, city & state)
CLINICAL PROVIDERS	Primary Care Provider			
	Psychiatrist			
	Therapist or Counselor			
	Social Worker or Case Manager			
	Facility or Program (if discharged within last 2 months)			
	Opiate Treatment Provider			
	Family Member			
	Other (please specify)			

By signing below, I understand that Inova Behavioral Health will contact the above care team for the purpose of care coordination. I understand that contact includes:

(1) a one-time letter to each clinical individual explaining I am receiving services from Inova Behavioral Health, and
(2) ongoing communication with each care team member as deemed necessary and appropriate by my Inova treatment team.

I understand I have the right to revoke this permission at any time.

Patient or Authorized Representative:

_____ _____ _____ _____

(signature) (print name) Date Time

Consistent with federal and state privacy regulations and as included in Inova's Notice of Privacy Practices, Inova may share information about you with others involved in your care. HIPAA does not require patient authorization to share patient information for treatment, payment, or health care operations purposes.

Interpreter Information (To be completed by Inova staff, if applicable):

☐ In person ☐ Telephonic ☐ Video Interpreter name/ID number (if applicable) _____

☐ Patient/Designated Decision Maker was offered and refused interpreter ☐ Waiver signed

PATIENT IDENTIFICATION

If label is not available, please complete:

Patient Name: _____

Date of Birth: _____ Medical Record # _____

Gender: ❑ Male ❑ Female

Inova Behavioral Health Services

Care Coordination

☐ IAH ☐ IFH ☐ IFOH ☐ ILH ☐ IMVH

☐ IMG: _____

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