BEACH COUNSELING CENTER
1064 LASKIN ROAD, SUITE 14C
VIRGINIA BEACH, VA 23451
(757) 233-1500 FAX (757) 222-3833

Confidential Exchange of INFORMATION FORM

Please complete this form and send it to the appropriate care provider(s) treating the member.

PATIENT NAME: **DOB:**

A. Treating Behavioral Health Clinician Information:

☐ Annie L. Phillips, LPC. Ph.D ☐ Lindsey Pyatt, LPC ☐ Patrizia Zorzoli, LPC ☐ Jenny Sachs, LCSW ☐ Scott Debb, LPC
☐ Jennifer Barnes, LCSW ☐ Debra Reese, LCSW ☐ Laurel Llobell ☐ Mark Warren, Ph.D. ☐ Joy Kannarkat, PsD.
☐ Heather Richardson, PA-C ☐ Robyn Leroy, Resident in Counseling ☐ Glenda Larcombe, Resident in Counseling
☐ Holly Waide, Resident in Counseling

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner Information:

Name: Phone:

Address: Fax:

C. Patient Clinical Information:

1. **The patient is being treated for the following behavioral health condition(s):**
   ☐ ADHD/ Behavior Disorder ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar Disorder ☐ OCD
   ☐ Self-Harm ☐ PTSD ☐Trauma ☐Postpartum Depression
   ☐ Depressive Disorder ☐ Anxiety Disorder ☐ Eating Disorder ☐ Adjustment Disorder
   ☐ Personality Disorder ☐ Other: ____________________
2. **The patient is being treated for (Diagnosis code):** ____________________

   ☐ Other:____________________
3. **Expected length of treatment**: ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year
4. **Date seen in office:** ____________________
5. **Coordination of care issues/Other relevant information impacting care:** ____________________

Date Mailed or Faxed to Other Practitioner/Facility: ____________________

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

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

Patient Signature **Date**

I do not want to have information shared with:

☐ My PCP/Medical practitioner ☐ I am not currently receiving services from a PCP/ other medical practitioner
☐ My other behavioral health practitioner(s) ☐ I am not currently receiving services from any other behavioral health practitioner

Behavioral Health Practitioner/Facility Representative Signature **Date**