



### Behavior Health Release Form

**MEMBER INSTRUCTIONS:**

Please bring this form to your In-Plan Behavioral Health (BH) Provider and have him/her complete and sign where noted. Once completed, the In-Plan BH Provider must mail or fax to the treating In-Plan Primary Care Provider (PCP). A copy must also be faxed to the Health Services department at 413-747-2612.

**TO:** In-Plan PCP Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**FROM:** In-Plan BH Provider: \_\_\_\_\_  
Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

This is to inform you that one of your patients, \_\_\_\_\_  
is currently in treatment with me. Below is a summary of behavioral health issues, progress, and treatment.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If you have any questions, or if I can be of any further assistance, please feel free to contact me at:  
Phone Number: \_\_\_\_\_

\_\_\_\_\_  
In-Plan BH Provider Signature Date

I hereby authorize my In-Plan BH Provider to disclose the above information to my In-Plan PCP.

\_\_\_\_\_  
Member Signature Date

\_\_\_\_\_  
Parent or Guardian Signature Date