Minuteman Health

One Monarch Place, Suite 1500, Springfield, MA 01144
855-644-1776 | MinutemanHealth.org

Medical Health Release Form

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

TO: In-Plan BH Provider: _____
Address: _____
Address 2: _____
City: _____ State: _____ Zip: _____
Phone: _____ Fax: _____

FROM: In-Plan PCP Name: _____
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 clinical 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 PCP Signature Date

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

_____
Member Signature Date

_____
Parent or Guardian Signature Date