Name of Facility: _____

Contact Person: _____

Telephone: _____

4. Refer all matters related to patient care, including, but not limited to, prescription refills, lab/imaging results and correspondence from consultants to the physicians who have agreed to cover for me, and provide the covering physicians with relevant information from the medical record.

5. Notify all active patients in writing using the letter drafted in accordance with my attorney's advice.

6. Release copies of medical records strictly adhering to the following protocols:

   - A written authorization, compliant with HIPAA and state law, must be signed by the patient prior to releasing or transferring medical records.
   - A copy of the authorization should be kept in the medical record.
   - If the patient submits an authorization form other than the one we currently use, please fax a copy of it to the risk management department of my malpractice carrier and ask for advice on whether to release the medical record:
   - If anyone other than the patient, such as an attorney, police officer, etc., request information on a patient, including a copy of the medical record, DO NOT release any information until you have consulted with risk management or the attorney managing this contingency plan or my estate for advice.
   - _____ (name),
     _____ (position),
     has keys/passwords needed to access medical records.

7. In the event of my death or incapacity also provide notice to:
   (Provide contact information for all that apply to your practice.)

   - Local pharmacies
   - DEA nearest field office
   - State licensing board
   - Insurance plans
   - Membership organizations
   - Other colleagues

_____
(Physician signature)

_____
(Date)

INITIATING MY CONTINGENCY PLAN

PRMS, Inc. has attempted to facilitate contingency planning by suggesting information relevant to initiating a plan. This form is not a complete contingency plan and the information it contains does not constitute legal advice. All physicians should consult with an attorney in their practice state for state-specific legal advice on contingency planning.

PRMS®
the psychiatrists' program®

PSYCHIATRIST NAME:

Home Address:

Home Telephone:

Cellphone:

Pager:

E-mail:

KEY CONTACTS

SPOUSE/SIGNIFICANT OTHER:

Address:

Home Telephone:

Cellphone:

FAMILY MEMBER/FRIEND:

Address:

Home Telephone:

Cellphone:

FAMILY MEMBER/FRIEND:

Address:

Home Telephone:

Cellphone:

OFFICE MANAGER:

Address:

Office Telephone:

Home Telephone:

Cellphone:

COVERING PSYCHIATRIST:

Office Telephone:

Cell Phone:

Home Phone:

Email:

COVERING PSYCHIATRIST:

Office Telephone:

Cell Phone:

Home Phone:

Email:

PERSONAL ATTORNEY:

Name:

Telephone:

Cellphone:

Email:

MALPRACTICE CARRIER:

Name:

Telephone:

Email:

IN THE EVENT OF MY SUDDEN DEATH OR INCAPACITY:

1. The key contact(s) having knowledge of the situation, should immediately notify the other listed key contacts.
2. In the event of my incapacity, I authorize _____ to carry out my contingency plan until such time as I return to or close my practice.
3. In the event of my death, I authorize _____ to carry out my contingency plan until such time as my practice is formally closed.

THE INDIVIDUAL(S) HAVING AUTHORITY TO CARRY OUT MY CONTINGENCY PLAN SHOULD:

1. Immediately notify patients with scheduled appointments and tell them Dr. _____ will be providing care to them until they can find a new psychiatrist or until I can return to practice (if this appears likely). Patients should be provided with contact information for the doctor.
2. Provide this information to patients who call the office during my absence/following my death.
3. Contact other entities where I provide care:

Name of Facility:

Contact Person:

Telephone: