INITIATING MY CONTINGENCY PLAN

PRMS has attempted to facilitate contingency planning by suggesting information relevant to initiating a plan. The following 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.

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PSYCHIATRIST NAME: _____

HOME ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

EMAIL: _____

KEY CONTACTS

1. SPOUSE/SIGNIFICANT OTHER: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

2. FAMILY MEMBER/FRIEND: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

3. FAMILY MEMBER/FRIEND: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

4. OFFICE MANAGER: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

5. COVERING PSYCHIATRIST: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

6. COVERING PSYCHIATRIST: _____

ADDRESS: _____

_____

HOME TELEPHONE: _____

CELL PHONE: _____

7. PERSONAL ATTORNEY: _____

TELEPHONE: _____

CELL PHONE: _____

EMAIL: _____

8. MALPRACTICE CARRIER: _____

TELEPHONE: _____

EMAIL: _____

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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 on the prior page.
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: _____

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., requests 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 info 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)