www.leecarlsoncenter.org

LEE CARLSON CENTER™
For Mental Health & Well-Being

7954 University Ave NE
Fridley, MN 55432
Tel (763) 780-3036
Fax (763) 780-0784

# ADULT REHABILITATIVE MENTAL HEALTH SERVICES REFERRAL FORM

Please complete this form and fax it along with the ROI to: 763-780-0784.

Date: _____

Referent Name: _____ Phone: _____

Agency: _____ ROI attached? Yes/No (circle one)

Client Name: _____ MALE/FEMALE (circle one)

Address: _____ City/Zip: _____

Social Security Number: _____ DOB: _____

Phone #: _____

MA # _____ Medicare # _____ PMAP # _____

Initial Diagnosis: _____

Does the client need an interpreter? If yes, what language? _____

Ethnic Cultural Values: _____

Has the client had a diagnostic assessment within the past 12 months? YES _____ NO _____

**If yes, please include the diagnostic assessment with the referral form**

| **Please indicate areas of need that apply to the client** | | | **Description of presenting problem** |
|---|---|---|---|
| Financial/Employment Assistance | YES | NO | |
| Educational Functioning | YES | NO | |
| Social Functioning | YES | NO | |
| Medical/Dental Assistance | YES | NO | |
| Mental Health Needs | YES | NO | |
| Sobriety Skills | YES | NO | |
| Self-Care | YES | NO | |
| Housing | YES | NO | |
| Community Resources | YES | NO | |
| Are there any safety concerns we should be aware of before sending a mental health practitioner to the client's home? If yes, please explain. | YES | NO | |

_____ _____

Referent Signature Date

www.leecarlsoncenter.org

LEE CARLSON CENTER™
For Mental Health & Well-Being

7954 University Ave NE
Fridley, MN 55432
Tel (763) 780-3036
Fax (763) 780-0784

# AUTHORIZATION/CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

| | |
|---|---|
| Client Information | Name: _____ Date of Birth: _____<br>Address: _____ Phone: _____<br>City: _____ State: _____ Zip: _____ |
| Information Release | ☐ I authorize Lee Carlson Center Staff to RECEIVE INFORMATION FROM (both orally and in writing):<br>☐ I authorize Lee Carlson Center Staff to RELEASE INFORMATION TO (both orally and in writing):<br>Provider/Person/Organization Name: _____<br>Address: _____<br>City: _____ State: _____ Zip: _____<br>Telephone: _____ Fax: _____ |
| Information to be released | ☐ Entire Health Record (includes all records below)<br>OR<br>☐ Part of Health Record (check one or more items below) dated from _____ to _____<br>☐ Diagnostic Assessment<br>☐ Psychological Evaluation/Testing<br>☐ Treatment Plan<br>☐ Progress Report/Summary<br>☐ Progress Notes<br>☐ Education Records/School Functioning<br>☐ Medication Notes<br>☐ Community Support Plan<br>☐ Chemical Dependency Treatment*<br>☐ Other (please describe): _____ |
| Purpose of Release | ☐ Continuing Care ☐ Coordination of Service ☐ Personal ☐ Legal ☐ Insurance/Disability<br>☐ Other (please explain): _____ |

* Regarding chemical dependency: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Acknowledgement of:

- I understand this authorization is valid for one year from the date of signature unless otherwise noted.
- I understand I may revoke this authorization at any time providing notification in writing, and it will be effective on the date notified except to the extent action has already taken place.
- I understand there may be a charge incurred for the copies of medical records pursuant to MN statute 144.292 and Rule 164.524.
- I understand a copy of this authorization will be treated in the same manner as the original.

- I understand when Lee Carlson Center discloses PHI pursuant to this authorization, we can no longer guarantee confidentiality or prevent-re-disclosure, and information may no longer be protected by federal privacy rules.
- I understand by signing this authorization I agree to allow Lee Carlson Center and all their staff members to disclose the following protected health information to the above stated person(s) or entity.
- I understand by signing this authorization I agree to all its contents and release Lee Carlson Center from any and all liability resulting from re-disclosure.

I further understand that my healthcare and payment for my entire healthcare will not be affected if I do not sign this form.

| | |
|---|---|
| Signature/Patient/Legal Representative<br>(Age 18 or older must sign for release of their records) | Date |
| Print Name of Representative | Relationship to Client |