

PARKER COLLINS

FAMILY MENTAL HEALTH

1056 Centerville Circle | Vadnais Heights, MN 55127
Phone 651.604.7771 | Fax 651.426.8116

Release of Information

Client name:		Client DOB:	
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I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164, Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Parker Collins in writing, but if I do, it will not have any effect on any actions Parker Collins took before it received the revocation.

I hereby authorize Parker Collins Family Mental Health, PLLC or designated staff to (check all that apply):

- Obtain records/information from: Release Records/information to:
 verbally: in writing:

Contact Name:			
Agency:			
Phone:		Fax:	

The information to be disclosed is:

- | | |
|--|--|
| <input type="checkbox"/> Mental health status report | <input type="checkbox"/> Psychological / psychiatric / intellectual assessment |
| <input type="checkbox"/> Progress notes / Treatment Plan | <input type="checkbox"/> Verification of program engagement / participation |
| <input type="checkbox"/> Chemical dependency evaluation | <input type="checkbox"/> Summary of presenting problem(s), diagnostic findings, treatment, discharge and summaries |
| <input type="checkbox"/> Case management notes | <input type="checkbox"/> Medical reports / health history |
| <input type="checkbox"/> Family/ social history | <input type="checkbox"/> School reports |
| <input type="checkbox"/> Court and probation records | |

Other (specify): _____

For the purpose of: (please specify why information is being disclosed):

- Treatment planning Record completion

I understand that this authorization will expire on: _____ or within one year from the below date, whichever is earlier.

_____ Signature of individual authorizing release	_____ Date
_____ Signature of witness (if required)	_____ Date
_____ Signature of parent/guardian (if required)	_____ Date

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Referral Form

REFERRAL SOURCE INFORMATION

Skip if the referral source is the same on the attached release of information

Referring Clinician: _____ Clinician NPI: _____
Agency: _____
Phone: _____ Fax: _____

CLIENT DEMOGRAPHICS

Client Name _____ Client DOB _____
Legal Gender _____ Phone Number _____
Parent/Guardian _____ Okay to leave message? yes no

DSM-V Diagnosis:

Other Conditions or
General Medical
Conditions:

INSURANCE INFORMATION

Insurer: _____
Insurance ID: _____
Insurance Group: _____

REFERRAL INFORMATION

(To be Completed by Referring Clinician)

Reason for Referral:

Psychosocial and Environmental Concerns:

Is the client currently seeing a Mental Health Provider? Who?

List All Known Medical Concerns/ Issues:

List All Medications:

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History of Substance Abuse (describe substance abuse history including substance use, last use, age at first use, treatment history, and outcome of treatment)

Substance	Age of first use	Frequency/duration	Notes

Other:

AREAS OF NEED

(To be Completed by Referring Clinician)

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SPECIALTIES/MODALITIES REQUESTED:

- EMDR
- Adaptive Internal Relational (AIR) Network

- Accelerated Resolution Therapy (ART)
- Dude therapy