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	

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:
☐ verbally:
☐ Release Records/information to:
☐ in writing:

Contact Name		
Agency		
Phone	Fax	

The information to be disclosed is:

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

☐ Other (specify): _____

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

☐ Evaluation report ☐ 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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Psychological Evaluation Referral Form

CLIENT DEMOGRAPHICS

Referring Clinician	
Clinician NPI	
Client ID	
Client Name	
Client DOB	
Client Age	
Client Gender	
Parent/Guardian	

DIAGNOSIS

DSM-V Diagnosis:

Other Conditions or General Medical Conditions:

INSURANCE INFORMATION

Insurer	
Authorization Required for Assessment?	
Is this the Initial Prior Authorization?	
Date of Diagnostic Assessment	
Was Client Referred for Assessment by Primary Care Provider? Who?	

ASSESSMENT INFORMATION

(To be Completed by Referring Clinician)

Reason for Testing: (Note: Please indicate what *specific clinical questions* will be answered through psychological evaluation that cannot be answered through comprehensive diagnostic interview, gathering of collateral information, and record review alone.)

How will The Results of Psychological Evaluation Facilitate Treatment Goals and/or Provide Information Beyond that Currently Available?

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Please Explain Any Academic Issues if Present:

Special Education?

Is this Service Court Ordered?

List All Known Medical Concerns/ Issues:

Date of Last Physical:

List All Medications:

History of Substance Abuse: (Note: 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:			

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Psychosocial and Environmental Concerns:

Has Previous Testing been Completed: (If yes, please obtain previous evaluation documentation for review *before* referring for assessment.)

Does the client require supervision/ observation during computer-administered testing? If so, why?

AREAS OF NEED
(To be Completed by Referring Clinician)

Select Area of Need	
Select Area of Need	
Select Area of Need	
Select Area of Need	
Select Area of Need	
Select Area of Need	
Select Area of Need	