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PARKER COLLINS
FAMILY MENTAL HEALTH

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: ☐ Release Records/information to:
☐ verbally: ☐ 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 ☐At the request of the individual
☐ other: Care coordination

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 Name: ______________________ Preferred Name ______________________
Client DOB: ______________________ Client Age: ______________________
Client Phone Number: ______________________ Client Gender: ______________________
Parent/Guardian: ______________________

Diagnosis:

INSURANCE INFORMATION

Insurer: Authorization Required for Assessment (Yes/No):
Date of Diagnostic Assessment*: _______________
***Please be sure to include most recent DA with referral.**

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?

Please Explain Any Academic Issues if Present:

Special Education? ______________________________________
Is this Service Court Ordered? _____________________________
Date of Last Physical: _____________________________________

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List All Known Medical Concerns/ Issues:

List All Medications:

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:

Psychosocial and Environmental Concerns:

Has Previous Testing been Completed? (If so, please indicate where and when)

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

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AREAS OF NEED
(To be Completed by Referring Clinician)

☐ ADHD	☐ Dissociation	☐ Psychotic Disorders	☐ Other: ______________
☐ Anxiety	☐ Intelligence	☐ PTSD/Trauma Issues	☐ Other: ______________
☐ Depression	☐ Learning Disabilities	☐ Suicidality	☐ Other: ______________
☐ Diagnostic Clarification	☐ Personality Issues		☐ Other: ______________

Additional information on areas of need:

For Internal Use:

Units Allowed Before Authorization

96130: ______________

96131: ______________

96136: ______________

96137: ______________

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