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 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 ☐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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Adolescent DBT Group Referral Form

CLIENT DEMOGRAPHICS

Referring Clinician: ______________________ Clinician NPI: ______________

Client Name: ______________________ Preferred Name ______________

Client DOB: ______________________ Client Age: ______________

Client Phone Number: ______________________ Client Gender: ______________

Parent/Guardian Name ______________________ Parent Phone Number ______________

Diagnosis:

REFERRAL SOURCE INFORMATION

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

Contact Name:			
Agency:			
Phone:		Fax:	

INSURANCE INFORMATION

Insurer:

Insurance ID:

Insurance Group:

Authorization Required for Assessment (Yes/No):

Date of Diagnostic Assessment*:

***Please be sure to include the most recent DA with referral.**

REFERRAL INFORMATION

(To be Completed by Referring Clinician)
Reason for Referral: Click here to enter text.
Psychosocial and Environmental Concerns: Click here to enter text.
Is the client currently seeing a Mental Health Provider? Who? Click here to enter text.

List All Known Medical Concerns/ Issues: Click here to enter text.
List All Medications: Click here to enter text.

History of Substance Abuse (describe substance abuse history including substance use, last use, age at first use, treatment history, and outcome of treatment)
Click here to enter text.

Substance	Age of first use	Frequency /duration	Notes
Other: Notes			

Please check the following criteria relevant to the client:

- ☐ 12-17 years old
- ☐ Experiencing a mental health crisis
- ☐ Intentional Self Harm (suicidal & non-suicidal)
- ☐ Diagnosis of disruptive mood dysregulation disorder
- ☐ Other mental health diagnoses including, but not limited to, a substance-related and addictive disorder
- ☐ Decompensation of mental health symptoms
- ☐ Risky impulsive behavior
- ☐ At risk for a need for a higher level of care, such as hospitalization or partial hospitalization
- ☐ Currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the person has managed to not act on them

Please indicate areas of functional impairment relevant to the client:

- ☐ Emotional dysregulation
- ☐ Interpersonal problems
- ☐ Reduced awareness and focus
- ☐ Impulsivity (including avoidance)
- ☐ Teenager and family challenges