Referral Form

Children's Respite - Rockland

RESPITE PROGRAM REFERRAL FORM

Please complete and return via secure email to smitha@greatermentalhealth.org or fax to 845-267-2169

CHILD/YOUTH NAME		**DATE OF BIRTH**		**AGE**	
PARENT/GUARDIAN NAME					
Home Address					
Home Phone		**Cell Phone**		**Email Address**	
Gender Identity		**Sex at Birth**			
School		**School District**		☐ IEP ☐ 504	**Grade**
Special Education Services					
Insurance Type	Medicaid ☐ Non-Medicaid (Private Pay Insurance) ☐ None/Uninsured ☐				
Reason for referral					
Any immediate SAFETY concerns? ☐ YES ☐ NO	Comments:				
Mental Health Diagnosis(es) – if applicable					
Medication(s), if applicable					
Child's Therapist (If applicable)		**Phone**			
Service(s) already in place					
Referral Source Name/Title		**Referral Date**			
Organization					
Email Address		**Phone**			

PLEASE INCLUDE CONSENT FORMS FOR THE PARENT/GUARDIAN AND REFERRAL SOURCE.

THIS SECTION FOR Greater Mental Health of New York

Forms Received Date		**Date of Initial Contact**	
Consent Forms Received			

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Children and Family Services
140 Route 303
Valley Cottage, NY 10989
Phone 914-598-6061
Fax 845-267-2169

As required by the Health Information Portability and Accountability Act of 1996, Greater Mental Health of New York may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein.

AUTHORIZATION SECTION

I, _____ [parent/guardian name] request that Health information regarding care and treatment of _____ [Date of Birth: ___/___/_____] be released as set forth on this form.

By initialing here _____ I authorize, **Greater Mental Health/Respite Staff** to discuss health information with the person or provider listed below.

Name, address and phone number of person or provider to disclose this information:
Respite Staff – Greater Mental Health of New York, 140 NY-303, Ste. E, Valley Cottage, NY 10989, 914-598-6061

Name, address and phone number of person(s) or provider to whom this information will be released:
PARENT/GUARDIAN:

Specific information to be released: (Please check all that apply)

__ Complete clinical/Mental Health Record
__ History and Treatment Plans
__ Client Face Sheet
__ Other: (please specify)
__ Intake information
__ Psychiatric Evaluation
__ List of Medication

Include: (By initialing)

_____ Alcohol/Drug Treatment
_____ Mental Health Information
_____ HIV-Related Information

For the following purpose: (staff, please check all that apply)

__ Billing
✓ Treatment
__ Operations
__ Other: _____

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I understand this authorization will expire when my child is no longer receiving services from Greater Mental Health of New York, or on the following event, condition, or date: _____

I understand the persons receiving this information following this authorization are prohibited by federal and state law from disclosing the information any further.

I understand that I am under no obligation to sign this authorization. I further understand that if I do not sign this authorization my child's ability to obtain treatment will not be affected.

FORM MUST BE COMPLETED BEFORE SIGNING

I have read this form and any questions about the release of information have been answered. By signing below, I acknowledge that I have read and accept all the above.

_____
Print Name of Individual or Personal Representative

_____ _____
Signature of Individual or Personal Representative **Date**

_____ _____
Witness **Date**

This program participant or his/her representative must be provided with a copy of this form after it has been signed.
If opting out of receiving a copy, which may be requested at a later date, please initial here: _____

REVOCATION OF AUTHORIZATION TO RELEASE INFORMATION

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to **Greater Mental Health of New York, Inc., 140 Route 303, Suite A, Valley Cottage, NY 10989 Attn: Compliance.** I further understand that such revocation does not apply to the extent that person or provider authorized to use or disclose my health information have already acted on this authorization.

I hereby cancel my permission to use/disclose information indicated above, as of this date: _____

_____ _____
Signature **Date**