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):

☐ 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

CLIENT DEMOGRAPHICS

Referring Clinician _____ Clinician NPI _____
Client Name _____ Client DOB _____
Client Gender _____ Client Age _____
Parent/Guardian _____ Client Contact _____
Phone Number _____ Okay to leave message? ☐ yes ☐ no

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 _____

REFERRAL INFORMATION

Reason for Referral:

Psychosocial and Environmental Concerns:

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

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 notes:

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AREAS OF NEED

Area of need:
Additional information:
Area of need:
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Additional information:
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Additional information:
Area of need:
Additional information:

SPECIALTIES/MODALITIES REQUESTED:

☐ EMDR
☐ Adaptive Internal Relational (AIR) Network
☐ Accelerated Resolution Therapy (ART)
☐ Dude therapy