COMMUNITY BASED SERVICES REFERRAL FORM

Referring Agency/Person Information		
Date of Referral:	Referring Agency/Person:	
Phone Number:	Email Address	
Send a ROI with referral if from an outside source		

Client Information		
Client's Name:		
Date of Birth:	Age:	
Gender: □ Male □ Female □ Other:		
Select services that client is being referred for (check all that apply) □ Adult Community Based Services A.) Independent Living Skills – Social Skills, Money Management Skills, Community Resources, Meal Preparation/Menu Planning Skills, Shopping Skills, Housekeeping Skills, and Symptom Management and Problem Solving Skills. □ Medication Management Services (Client must be approved for ARMHS Services and have MA) If checked, please check frequency: □ Daily □ Weekly □ Bi-Weekly □ Adult Mental Health Case Management		
Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Permission to leave a message? □ Yes □ No		
SS #:	Marital Status:	
Medicare #:	MA#:	
Other Insurance:	Co. of Financial Responsibility:	
Psychiatrist:	Therapist:	Case Manager:
Diagnosis & ICD-10 Code:		
Primary Care Provider & Location:		
Medical Conditions:		
Pharmacy (Only for Med Room Referrals):		
Hospitalization for mental health within the last 2 years? □ Yes □ No		
Is the client on a commitment? □ Yes □ No		
Currently receiving Hiawatha Valley Mental Health Center Services? □ Yes □ No		
Is there a referral in the Diagnostic Assessment for ARMHS or medication management? □ Yes □ No		
Reason for Referral:		
Please send the following information along with the referral: □ Most recent Diagnostic Assessment □ Current list of medications for Medication Management Referrals □ Release of Information if referring from an outside agency		

Please return the completed form to the ARMHS Coordinator at 1433 West Service Drive, Winona, MN 55987.
Fax: (507) 474-4590 or Email: katem@hvmhc.org
If you have any questions, please call Kate Meyer at (507)-429-9885 or Christy Ferrington at (507)-459-6539.

Hiawatha Valley
MENTAL HEALTH CENTER

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

CLIENT NAME: _____ DOB: _____ ID # _____
Last Name First Name Middle Name

HEREBY AUTHORIZES: Hiawatha Valley Mental Health Center

Address: City, State, Zip:

Phone: Fax: Email:

To: ☐ **Receive from** ☐ **Release to** ☐ **Exchange with** ☐ **Verbal Exchange with**

Name of Person/ Facility Receiving the Request _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Check the Type of Information to be disclosed

☐ Admission/Intake Summary ☐ Complete Health Record ☐ Consultation Reports
☐ CD Assessment ☐ Client History ☐ Discharge Summary
☐ Diagnostic Assessment ☐ Financial ☐ Prescriptions
☐ Progress Notes/Case Notes ☐ Psychiatric Evaluation ☐ Psychological Testing
☐ Collateral Contact _____
☐ Other (specify) _____

State and Federal Laws require specific authorization prior to disclosing certain information. Please check if you would like any or all of the following information disclosed

☐ Behavioral Health Service/Psychiatric Care ☐ Treatment for Alcohol and/or Drug Abuse

☐ Developmental Disabilities

☐ Psychotherapy Notes (conversational analysis) **No other items can be checked when requesting this item**

Time period for the information that I want to be released includes

☐ All Available History ☐ Specific Time Period From _____ To _____

Purpose or Need for Release

☐ Treatment/Further Health Care ☐ Insurance/Financial ☐ Legal Investigation
☐ Disability Determination ☐ Changing Therapist ☐ Personal
☐ Visit Child in School ☐ Other (specify) _____

Expiration Date of This Release

This authorization will expire one year from the date of your signature unless I indicate an earlier date or event here: _____. This authorization covers records that were created or existing on or before the date this authorization was signed, as well as records that are created after the date this authorization is signed, up until the expiration date. If I elect to revoke this authorization prior to its annual renewal date, or the designated date I selected, I understand that HVMHC cannot be held responsible for any records already released prior to written notification, to the appropriate employee, that I am revoking my consent.

Your Rights with Respect to This Authorization

Federal and state laws protect the confidentiality of this protected health information. These laws include Mental Health – Sec 51.30, Wis. Stats; & HFS 92m Wis. Admin. Code. Alcohol & Other Drug Abuse – Sec. 51.30 Wis. Stats, HFS 92, Wis. Admin. Code; and 42 CFR Part 2 Final Rule. This information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). These laws prohibit any further disclosure of this protected health information without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164.

- Right to Inspect or Copy the Health Information to be Used or Disclosed: I have a right to inspect or copy the health information that is to be used or disclosed. I may be charged a reasonable fee for these copies.
- Right to Receive a Copy of this Authorization: I have a right to receive a copy of this form after I sign it.
- Right to Refuse to Sign This Authorization: I understand I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information m ay not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits on my decision to sign this authorization.
- Re-disclosure: Protected health information may be subject to disclosure and no longer protected by the regulations if disclosed to an individual/agency not covered by federal or state laws.
- Right to Withdraw This Authorization: I have the right to withdraw this authorization at any time by providing a written statement revoking my consent to the agency disclosing the protected health information. My withdrawal of consent will not be effective until the proper employee at HVMHC received the written revocation. HVMHC cannot be held responsible for records already released prior to the written notification being received.

The facility, its employees, psychiatrist, and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. By signing this authorization, I am confirmation that it accurately reflects my wishes.

Your signature to disclose this information allows Hiawatha Valley Mental Health Center to release your information by means of postal courier, faxes, and encrypted secure email.

Signature: _____Date of Authorization: _____
(MN Resident - 18 years or older -Minn. Stat. §645.451/ WI Resident - 14 years or older-Wis. Stat. § 51.14)

Parent or Guardian Signature: _____Date of Authorization: _____
(If Applicable)

HVMHC Staff Initials verifying completion of authorization: _____

Client is:

☐ A Minor ☐ Incompetent ☐ Disabled ☐ Deceased

Legal Authority:

☐ Custodial Parent ☐ Legal Guardian ☐ Power of Attorney ☐ Executor of Estate of Deceased ☐ Legal Authorized Representative

Sending records FROM HVMHC Only

For Office Use Only:

☐ Mail Records ☐ Fax Records ☐ Pick Up Records ☐ Email

☐ No Records Needed at This Time – File for Future Use