

Your letterhead

Mental Health Referral Form

Referred to (clinic or agency): _____

Referred by (physician & clinic): _____

Address: _____

Phone: _____ Fax: _____

Name of individual being referred: _____

Date of birth: _____ Sex: _____ Social Security number: _____

Address: _____ City: _____ State: _____

Home phone: _____ Work phone: _____ Cell phone: _____

Name of parent/guardian: _____

Reason for Referral: _____

Information to be disclosed:

Clinic progress notes Psychiatric evaluation Psychological evaluation

Lab data Pathology reports Radiology reports

Cardiology reports Immunization records

All records Other

Purpose of disclosure:

Continuing medical care

Insurance claim

Consultation/second opinion

Legal

Out-of-town move

Personal

Other _____

Expiration Date: This authorization will expire one year from the date of signature or on _____.

Revocation: I understand that I may revoke this authorization at any time by sending written notice to the health care facility noted above. However, the revocation is not valid if 1) action was previously taken in reliance on this authorization; or 2) this authorization is obtained as a condition for obtaining insurance coverage; other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Authorization: I authorize the physician noted above to refer my child for mental health services to the clinic or agency noted for the reasons stated. Also, so that they may coordinate care and treatment for my child, I give my permission for the physician and mental health professional to communicate about the needs and courses of action with respect to my child.

Parent's/Representative's Signature

Relationship to patient (if signed by representative)

Date