CHILD'S PLAY
BEHAVIOR ANALYSIS

REFERRAL FORM

1) _____
Name Address City State Zip

_____ (_____)_____
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

_____
Name of Health Care Provider / Plan / Other

_____
Address

3) **TO DISCLOSE TO:**

Child's Play Behavior Analysis
4118 N. Clinton St
Fort Wayne, IN 46805

Ph. 260-373-1050
Fax. 260-471-0285

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)**

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From _____ (month/year) to _____ (month/year) If left blank, information from the past two (2) years will be disclosed.

6) **INFORMATION TO BE DISCLOSED:** ☐ **Verbal** ☐ **Written**

☐ Alcohol / Drug Abuse Assessment ☐ Discharge Instructions ☐ Discharge Summary ☐ History & Physical
☐ Identity and Presence in Treatment ☐ Initial Mental Health Assessment ☐ Lab Results ☐ Legal Status/Court Records
☐ Medications/Medication Profile ☐ Outpatient Mental Health/AODA Records ☐ Progress Notes/Updates
☐ Psychiatric Evaluation ☐ Psychosocial Assessment ☐ Treatment Plan
☐ Billing Records related to (specify): _____
☐ Other (specify): _____
_____

☐ **CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXIST) TO BE DISCLOSED**

7) **EXPIRATION:** This Authorization is good until the following date / event: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

8) **PURPOSE** (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility / Benefits
☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment
☐ Other: _____

9) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim / policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and / or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10) **SIGNATURE OF PATIENT:** _____ **DATE:** _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____ **DATE:** _____

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated
2. Legal authority: ☐ parent* ☐ legal guardian ☐ activated POA for Health Care

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AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH INFORMATION
(Consent)