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| AUTHORIZATION FOR BEHAVIORAL HEALTH AND PRIMARY CARE PROVIDER  TO SHARE CONFIDENTIAL INFORMATION |
| I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give permission to Laurie Hochman, LICSW and my Primary Care Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history. I understand the purpose of sharing information is to help me receive better care.  This consent form expires one (1) year from the date of signing and I can choose to cancel it at any time.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Individual/Guardian/Authorized Representative Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Date |

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| REFERRAL FROM PRIMARY CARE PROVIDER TO LAURIE HOCHMAN, LICSW |
| Reason for referral: |
| The patient is being treated for the following medical problems: |
| The patient is taking the following medication(s): |
| The patient has the following behavioral health issue(s): |
| Please describe any special concerns: |

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| PRIMARY CARE PROVIDER | |
| NAME: | SIGNATURE: |
| ADDRESS: | |
| PHONE: | |
| FAX: | |

Please fax completed forms to the attention of Laurie Hochman, LICSW at (401) 921-5014

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| AUTHORIZATION TO DISCLOSE CONFIDENTIAL HEALTHCARE INFORMATION |
| I, (CLIENT NAME)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (DOB) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Hereby authorize LAURIE HOCHMAN, LICSW to share information about my diagnosis and/or treatment related to substance abuse, mental health, and/or medical history.  LAURIE HOCHMAN, LICSW MAY  RELEASE TO AND/OR OBTAIN FROM:  NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  TITLE/RELATIONSHIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  AGENCY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  TELEPHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The following information may be disclosed (Please Specify):  Any and All Information Pertinent to Treatment  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  The purpose(s) of the use or disclosure are: Coordination of Care Client Request  By signing this authorization form, you authorize the use or disclosure of your protected health information as described above. This information may be redisclosed if the recipient of this information is not required by law to protect the privacy of the information. Substance abuse information is protected by federal rules (42 CFR), and requires specific authorization.  You have the right to refuse to sign this authorization. Your healthcare, the payment for your healthcare, and healthcare benefits will not be affected if you do not sign this form. You have a right to see a copy of the information described on this form in accordance with the policies of Laurie Hochman, LICSW. You also have a right to receive a copy of this form at your request.  If you sign this authorization, you have the right to revoke it at any time, except to the extent that Laurie Hochman, LICSW has already taken action based upon your authorization. To revoke this authorization, please write to Laurie Hochman, LICSW. If there is no specification, this authorization will expire no longer than 24 months from the date this form was signed.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Individual/Guardian/Authorized Representative Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Witness Date |