FAMILY HEALTH
La Clinica

Family Health La Clinical Behavioral Health Referral Form

Scheduling Phone Number: 1-800-942-5330, Fax Number: 608-474-4309

Thank you for your referral to Family Health La Clinica!
Please provide the following information and pertinent clinical documents so that we can provide the best and most timely service!

Patient Information	Referring Provider Information
Patient Name:	Referring Agency:
Parent/Guardian Name(s):	Ref Agency Contact:
Patient Address:	Provider Name:
Date of Birth:	Agency/Provider Address:
Phone Number:	
Insurance Provider:	Phone Number:
Subscriber ID#:	Fax Number:

Please complete the following information in its entirety:

1. Reason for referral. Please also list most concerning mental, behavioral health, and AODA symptoms:_____

_____

_____

_____

2. Please list past/current mental health diagnoses:_____

_____

3. Please list name and agency of current counselor, if applicable:_____

4. Please list name and agency of psychiatry provider, if applicable:_____

5. I am referring the patient for the following services:

☐ Mental Health Counseling (short-term or long-term psychotherapy)

☐ Psychiatry (psychotropic medication management beyond scope of primary medical provider)
***Current medication list is required for all psychiatry referrals**

☐ AODA Counseling and/or Medication Assisted Treatment (short-term or long-term counseling for substance abuse; assessment for medication assisted substance abuse treatment)

6. Is the patient's parent/guardian aware and in agreement with referrals for the services checked above?
☐ Yes ☐ No- Explain:_____
****If patient under 18, legal guardian must attend in-person with patient to sign consent forms**

7. Have you included any previous psychological evaluations or other relevant mental health history records?
☐ Yes ☐ No

8.Have you included a signed ROI so that we may reach out and get any health records that we need on behalf of the patient?
☐ Yes ☐ No

FAMILY HEALTH La Clinica

AUTHORIZATION FOR RELEASE/OBTAIN INFORMATION

Medical/Dental/Behavioral Health

For Office Use Only:
Assisting Staff Initials/Date
_____
_____

400 S. Townline Road
Wautoma, WI 54982
P-920-787-5514 F-920-787-4737

I,_____, DOB_____ authorize **Family Health La Clinica**
(Name of Client)

TO DISCLOSE INFORMATION/TO OBTAIN FROM (circle one/or both):_____
(Name of Person and/or Organization)

_____
(Address/City/State/Zip)

Information to be Released (check all appropriate categories)

☐ ***Medical*** ☐ ***Dental*** ☐ ***Behavioral Health***

☐ All medical records related to (specify condition, treatment, etc): _____
☐ All dental records related to (specify condition, treatment, etc): _____
☐ Radiology/X-rays/films/images (specify test): _____
☐ Other (specify): _____

☐ Alcohol/Drug Abuse Assessment	☐ Discharge Summary	☐ History & Physical	☐ Lab Results	☐ Progress Notes
☐ Treatment Records (outpatient)	☐ Initial MH assessment	☐ Legal/Court	☐ Psychiatric Eval	☐ ER Report
☐ Treatment Records (inpatient)	☐ Biopsychosocial	☐ Referrals	☐ Therapy Notes	☐ MH Diagnosis
☐ Medication Profile	☐ HIV/AIDS Test Results	☐ Consults	☐ AODA Treatment	

☐ Specific records/information as follows: _____
☐ All billing records related to (specify condition, treatment, etc): _____

***Purpose (check all that apply):** ☐ Continuity of Care ☐ Legal ☐ Workers Compensation ☐ Insurance Eligibility
☐ Obtain Collateral Contact ☐ Transition of Care ☐ Personal (at my request) ☐ Verify Compliance with Treatment
☐ Other (specifiy):_____

***Period(s) from when Written Record Documentation to be released: From _____ to_____**

I understand that my records are protected under the Federal and State confidentiality laws and regulations and may not be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time.

I understand that if the person(s) and/or organization listed above are not health care providers, health plans, or health care clearing houses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

***YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION**

Right to inspect or receive a copy of the health information to be used or disclosed-I understand that I have the right to inspect or copy the health confidential information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting the health information department. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under HHS 92.05 and 92.06 of the Wisconsin Administrative Code. **Right to Receive Copy of this Authorization**- I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse this Authorization** – I understand that I am under no obligation to sign this form and the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw this Authorization** - I understand that written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization, I may contact FHLC staff providing/coordinating my services. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization

***EXPIRATION DATE:** This authorization is good until the following date(s)_____ or for one year from the date signed, up to and including treatment dates created after the date of signature. I have had the opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Patient/Patient Representative (list relationship): _____

_____ **Date:** _____
Signature