Mat-Su Health Services, Inc.
Referral Form

Date: _____ **Last Name (Legal):** _____

First Name (Legal): _____ **Middle Name (Legal):** _____

Nickname/Preferred Name: _____

Age: _____ **DOB:** _____ **Primary Language:** _____

Parent/Legal Guardian: _____

Mailing Address: _____
Street City State Zip Code

Phone: _____

Insurance: ☐ Yes ☐ None
Insurance Company Name: _____

Medicaid: ☐ Yes **Medicare:** ☐ Yes

Referral Source

Agency name: _____

Phone number: _____

Person Referring: _____

Is this urgent? ☐ YES ☐ No

Reason for seeking services:

☐ Mental Health Counseling
☐ Substance Use/Addictions
☐ Primary Care
☐ OnTrAK (First Episode of Psychosis)
☐ Psychopharmacology
☐ Dental

ROI Attached: ☐ Yes **(Please attach)**

Additional Comments:

Please fax or email this referral form with completed ROI to Mat-Su Health Services.

Mat-Su Health Services, Inc.
1363 West Spruce Ave, Wasilla, AK 99654

Main Phone: 907-376-2411

Fax Number: 907-352-3373

Direct Number for Medical Records: 907-352-3328

Email: records@mshsak.org

Approved: 7/30/2025

Authorization to Release Records or Information

I AUTHORIZE: Release To: ☐ Obtain From: ☐ **Please Initial**

MAT-SU HEALTH SERVICES, INC.
1363 W. Spruce Ave.
Wasilla, Alaska 99654
PH: 907-376-2411
Fax: 907-352-3373
Email: records@mshsak.org

Name of Person or Agency _____

Street Address _____

City **State** **Zip Code** _____

PH: **Fax:** _____

Requested Dates: Most Recent ☐ Last 6 months ☐ Last Year ☐ Other ☐ _____

*** INITIAL below all that apply:**

_____**Discharge Summary**	_____ **Therapy Notes**	_____**Office Visit**
_____**Intake Assessment**	_____ **Therapy Notes: SUD***	_____**Labs**
_____**SUD Assessment***	_____**Case Management**	_____**Labs: SUD***
_____**Psychiatric Evaluation**	_____**Community Based Services**	_____**Medications**
_____**Treatment Plan**	_____**Office Visits: Psychiatric**	_____**Medications: SUD***
_____**Verbal**	_____**Dental/Radiographs**	_____**Imaging**
_____**Other:** _____		**SUD: Substance Use Disorder*

Receive by: Mail ____ Fax ____ Pick Up ____ Verbal ____ Electronic_____
Purpose of the Request: Treatment _____ Legal _____ Insurance _____ Personal _____ Other_____

**I understand that information in the Health Record may contain information relating to mental health or behavioral health, alcohol and drug abuse, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV).*
**I understand that I have a right to revoke this authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.*
**I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.*
**I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.*
**I understand I have the right to receive a copy of this authorization form. I also understand that upon my written request, MSHS must provide me a record of any subsequent disclosures made for legal, administrative, or quality assurance purposes.*

Client Name (Please Print) _____
Date of Birth: _____ Phone Number: _____
Client Signature: _____ Date: _____
(Minor's signature is required with regards to drug and alcohol information)
Parent/Guardian: _____ Date: _____
Witness: _____ Date: _____
This authorization will terminate one year from the date signed, or unless an earlier date or condition / event is specified here:

_____

Recipient Information: If the information released pertains to alcohol or drug abuse, the confidentiality of the information is protected by federal law (CFR 42 Part 2) prohibiting you from making any further disclosure of this information without the specific written authorization of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.
This authorization is revoked: _____ Date: _____

Service Provider to Complete
__ Send for Records __ Send Authorization
__ Release MSHS Records __ File Authorization

For Office Use Only

07/2025 - CMK