HEALTHY AVENUES MEDICAL GROUP

Referral for Evaluation & Out Patient Services

Date of Referral: _____ **Please Attach- (ROI) AUTHORIZATION FOR RELEASE OF INFORMATION, DL, & Insurance if possible**	
Referring Agency:	
Referring Clinician/Contact:	**Phone:**
Referring Email Contact:	**Fax:**
Client Referred:	**Client's Phone:**
DOB:	**Alt Phone:**
Parent/Guardian:	
Relationship to Patient:	**Phone:**
Primary Reason for Referral and/or Behavioral Health Diagnosis:	

Requested HAMG Services: ☐ **English** ☐ **Spanish**

☐ Initial Assessment/ Evaluation

☐ Medication Management

☐ Psychiatric Evaluation

☐ Play Therapy

☐ Individual, Family or Couples Therapy

☐ Adolescent SUD IOP (13-17yrs)

☐ Transitional Age SUD IOP (18-25yrs)

☐ Adult SUD IOP (26yrs +)

☐ **Drug Testing**

☐ Other Services: _____

REFERRAL SIGNATURE:	**DATE:**

To Schedule call (504) 377-6628
OR
Email form to: HAMG@healthyavenuesmedicalgroup.com
Healthy Avenues Medical Group Fax: (504) 766-9788

Authorization to Release or Obtain Health Information

(Including paper, oral and electronic information)

Important Information about Authorization

Authorization means to give permission or approval. We need your authorization before we can use, disclose or release, or obtain your health information for some of our services.

An authorization is voluntary. To give us your authorization you would sign this form. If you agree to sign this form, you will be given a signed copy.

You do not have to sign this form. If you do not sign, you are still eligible to receive some services and payment for health care services.

At times your authorization is required by law or policy before some services can be delivered. If your authorization is required by law or by policy, we will use and disclose or release your health information as you have authorized on the signed form. **§ 2.32 Notice:***42 CFR Part 2 prohibits unauthorized use or disclosure of these records.*

When required by law or policy, we may only obtain, use and disclose or release your health information if the required written authorization includes all required elements of a valid authorization.

You may be required to sign an authorization form before receiving research-related treatment. You may be required to sign an authorization form before sharing your protected health information for disclosure or release to a third party.

Example: In juvenile court proceedings where a parent is required to obtain a psychological evaluation on their minor child by Healthy Avenues Medical Group, LLC, the parent may be required to sign an authorization to release the evaluation report (but not the psychotherapy notes) to the requesting court.

You may cancel an authorization in writing at any time. We cannot take back any uses, disclosures or releases already made before an authorization is canceled. Information used, disclosed or released by this authorization may be re-disclosed or released by the recipient and will no longer be protected by our privacy policies.

NOTE: Healthy Avenues Medical Group, LLC does not release records received from other health/human services providers on your behalf.

Authorization to Release or Obtain Health Information

(including paper, oral and electronic information)

Client's Name _____ Request Date: _____

Mailing Address: _____ Date of Birth: _____

City/State/Zip: _____ Social Security #: _____

I Authorize the below party :

Name: _____

Mailing Address: _____

City, State, Zip Code: _____

Relationship : _____ Telephone Number: _____

☑ **TO RELEASE information TO** **AND / OR** ☑ **TO OBTAIN Information FROM**

(Place an "X" in the box that indicates if the information is being released OR requested.)

Name: Healthy Avenues Medical Group

Mailing Address: 3303 Tulane Ave Bldg 1

City, State, Zip Code: New Orleans LA 70119

Relationship: BH Provider Telephone Number: 504.377.6628

The **Purpose of this Authorization** is indicated in the box(es) below. (Place an "X" in the box(es) that apply.)

☐ Further Medical Care ☐ Personal ☐ Legal Investigation or Action ☐ Changing Physicians
☐ Research related treatment ☐ Insurance ☐ Creating health information for disclosure to a third party
☐ Other: (Specify) _____ .

I Authorize the release of the following protected health information.
(Place an "X" in the box(es) that apply to the *information* you want released or you want to obtain.)

☐ Entire Record ☐ Medical History, Examination, Reports ☐ Surgical Reports ☐ **Progress Reports**
☐ Prescriptions ☐ Immunizations ☐ Hospital Records Including Reports ☐ Laboratory Reports
☐ X-ray Reports ☐ MR/DD Records ☐ Other: _____

In compliance with state and/or federal laws, which require special permission to release otherwise privileged information,please release the following records: § 2.32 Notice: *42 CFR Part 2 prohibits unauthorized use or disclosure of these records.*

☐ Alcoholism ☐ Drug Abuse ☐ Mental Health ☐ Vocational Rehabilitation ☐ HIV (AIDS)
☐ Sexually Transmitted Diseases ☐ Genetics ☐ Psychotherapy Notes ☐ **Drug Test Results**
☐ Other: _____

Release Specific Date(s) of Service/ Event date: _____

Release Records Selected from Beginning Date: _____ **TO End Date:** _____

This Authorization shall expire on : _____

If I fail to specify an expiration date, event or condition, this authorization will expire (6) months from the date on which it was signed. I acknowledge I have read pages 1 and 2 of this form.

_____ _____
Signature of Individual **Date**

_____ _____
Signature of Legal Representative/Guardian Authorized by Law **Date

_____ _____
(Print Full Name) Individual/Guardian/Legal Representative Authorized by Law **Phone Number**

****If a patient is unable to sign, secure consent of the Legal Representative and indicate reason. Proof of Designation must be filed in record or sent along with request.**