Partnership *for* Children

Referral Application for Services

Email to kstevens@pfcmt.org or fax to : (406) 541-5532

Check all services that would be helpful for referral:

☐ **Substance Use Treatment** ☐ **Mental Health Evaluation** ☑ **Project Welcome**

☐ **Outpatient Therapy** ☐ **Targeted Case Management** ☐ **Peer Support**

☐ **Home Support Services** ☐ **Perinatal Mental Health** ☐ **Chemical Dependency Evaluation**

Date: _____ Referring Agency or Individual: _____

Reason for Referral: _____

Contact Person: _____ Phone: _____

Email Address: _____

Address: _____

City: _____ State:_____ Zip code: _____

Client Name: _____Phone: _____

Email Address: _____

DOB: _____ Age:_____ SSN: _____

Race: _____ Tribal Affiliation (if any): _____

Home Phone: _____ Work Phone: _____

Address: _____

City: _____ State: _____ Zip code: _____

Current Insurance Provider: _____ ID # :_____

Additional Information:

Partnership for Children
Authorization to Release Information

Name: _____ Date of Birth: _____ SSN: _____

I herby authorize Partnership for Children, 2825 Stockyard Rd Ste A-11, Missoula, MT 59808, and the following named agency, organization and/or persons, to communicate with and disclose to one another my protected health information as indicated below:

Name: _____ Relationship: _____

Organization\Agency: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____ Email: _____

Information to be released or obtained (check each box)

☐ Treatment Status	☐ Family Program info	☐ Treatment Plan
☐ Admission/Progress/Compliance	☐ Discharge Summary	☐ Parent-Child Therapy Records
☐ Assessment/Recommendations	☐ Intake/Assessment Summary	☐ Cost of Treatment/Billing info
☐ Continued Stay Reviews	☐ Progress report	☐ Entire Treatment Record
☐ Continuing Care Plan	☐ Progress Notes/MD notes	☐ Diagnostic Impressions
☐ Bio-Psych-Social Info	☐ Psychiatric Evaluation/Records	☐ Treatment Recommendations

Purpose of disclosure

_____

Method of Disclosure: ☐ Mail ☐ Email ☐ Phone ☐ Fax ☐ In-person

I understand that my alcohol and/or drug treatment records are protected under the Federal regulations governing Confidentiality and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.
I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in

reliance on it. This consent expires on: _____
(specify date, event, or condition upon which consent expires)

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations. I will not be denied services if I refuse to consent to a disclosure for other purposes. I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may no longer be protected by federal confidentiality rules. I have read and understand this authorization.

Client Signature: _____ **Date:** _____

Guardian Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

NOTICE TO WHOMEVER DISCLOSURE IS MADE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.