Advanced Pediatric Associates LLP

CONFIDENTIAL MENTAL HEALTH REFERRAL/COMMUNICATION FORM

Advanced Pediatrics would like to facilitate communication as we jointly care for this patient by the use of this communication form. Please complete this form or send a copy of your chart notes with pertinent information regarding your care for this patient via fax to 303-766-6903. If you prescribe or recommend any medications it is especially important to provide this information as we are unable to provide any medication management unless we have current information regarding progress and course of treatment. A signed release form from the patient/parent is attached. Please feel welcome to contact me at any time at 303-699-6200. Thank you for your participation in the care of this patient.

Patient Information

Date: _____

Patient Name:_____ DOB: _____

Parent's Name: _____ Phone: _____

Reason for Referral/Request for Information/Comments:

_____

_____

_____

_____

Primary Care Provider/Signature _____

Mental Health Provider Report

Date(s) patient seen:

_____

Initial Diagnoses:

1. _____
2. _____
3. _____

Recommendations/Comments:

_____

_____

_____

_____

_____

Medication/Dosage prescribed/recommended**:**

_____

Name/Signature: _____

Phone Number: _____

Advanced Pediatric Associates
Authorization to Use or Disclose Health Information

Patient Name(s): _____ DOB: _____

My Authorization

You may use/disclose/transfer the following health care information (check all that apply)

☐ All health information maintained by Advanced Pediatric Associates

☒ All health information maintained by _____

_____

☒ I specifically authorize the release of information regarding the following conditions:

☐ *Drug Abuse (if any)* ☐ *Substance Abuse (if any)*

☐ *AIDS/HIV (if any)* ☒ *Psychological/Psychiatric Conditions (if any)*

☐ Other: _____

You may disclose this information to:

Name or Organization: Advanced Pediatric Associates

Address: 5657 S. Himalaya St., # 100, Centennial, CO 80015 303-766-6903 (Fax)

The reason for this authorization is:

☐ Permanent transfer of records ☐ Copies for my personal files

☐ Copies for specialist/school/daycare ☒ Other For Joint Care and Communications

Acknowledgement of Charges for Copying of Records

I acknowledge that in accordance with the Colorado Department of Public Health and Environment a fee may be charged for copies of medical records. The charge is $14.00 for the first ten or fewer pages and 30 cents for every additional page. Actual postage may also be charged if applicable. There is no charge for physician to physician record transfers.

My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization in writing or by completion of a revocation form available from the practice. If I do, it will not affect any actions already taken by the above named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the practice discloses health information the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

This authorization expires six months from the date of signature or on _____.

A copy of this authorization may be utilized with the same effectiveness as the original.

Signature

_____ _____

Patient or legally authorized signature *Date*

_____ _____

Printed name if signed on behalf of the patient *Relationship (parent, legal guardian)*

_____ _____

Address *City, State, Zip*

_____

Phone