-OPTIONS Family & Behavior Services
151 W. Burnsville Parkway Suite 100
Burnsville, MN. 55337
Phone: 952-564-3000 Fax: 651-925-0256

REFERRAL
Adult Rehabilitative Mental Health Services (ARMHS)

Referral Source:
Name: _____ Date Submitted: _____
Agency: _____
Phone: _____

Client Name: _____ Date of Birth: _____
Address: _____ SSN: _____
_____ Insurance: _____
Phone: _____ Policy Number: _____
PMI: _____

Mental Health Diagnosis:
_____
_____

Potential Goal Areas:
_____
_____
_____

Other Client Information:
Is client their own guardian? ___Yes ___No
If no, who is the client's guardian? _____
Does the client know you are making the referral? _____
Is a Diagnostic Assessment available? ___Yes ___No Copy Requested: ___Yes ___No
Does the client live on their own or in a group home/ assisted Living?
_____
Do they have a spend down? ___Yes ___No Who is it to? _____
What is the spend down amount? _____
Miscellaneous information:
_____
_____

OPTIONS Family & Behavior Services

(A Division of Community Drug & Alcohol Services, Inc.)

www.optionsfamily.com

2675 Long Lake Rd; Suite 125
Roseville, MN 55113
Phone: 651-209-6632
Fax: 651-209-8872

151 West Burnsville Pkwy; Suite 100
Burnsville, MN 55337
Phone: 952-564-3000
Fax: 651-925-0256

Release of Information

Client name: _____ Date of Birth:

_____

I authorize OPTIONS Family & Behavior Services and Community Drug & Alcohol Services to:

_____ ☐ Receive information from:
_____ ☐ Release information to:
_____ ☐ Release and receive information to/from: Name/Credentials: _____

Agency: _____ Relationship:

_____

Address: _____ Phone:

_____Cell_____

City, State, Zip: _____ Fax: _____

Work_____

Check and **initial** all types of information that may be released and/or obtained to/from above party:

_____ ☐ Treatment/Discharge Summary
_____ ☐ Chemical Dependency/Mental Health Assessment
_____ ☐ Progress Reports and Continuing Care
_____ ☐ Psychological Testing/Evaluation
_____ ☐ Psychiatric Consultation
_____ ☐ Verbal (In-person or phone conversation)
Doctor notes
_____ ☐ School Reports/Records

_____ ☐ Social History
_____ ☐ Family History
_____ ☐ Legal History
_____ ☐ Medical history
_____ ☐ Laboratory Reports
_____ ☐ Physical Examination &
_____ ☐ Other:

_____

This release is limited as follows: _____

_____

This information is to be disclosed for the following purpose:

Treatment Planning, Coordination of Services, and Continuity of Care

- My health information is protected by federal regulations (Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and/or HIPAA, 45 CFR) and state privacy laws, and disclosure is allowed only with my authorization except in limited circumstances described in OPTIONS Family & Behavior Services Privacy Notice. I understand that I have a right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state of federal laws.
- I can revoke this authorization at any time except to the extent that action has been taken in reliance on it. OPTIONS Privacy Notice outlines the procedure for revocation. This authorization will expire in one year from the date I sign it unless I request an earlier expiration in writing.
- For disclosures other than for treatment, payment and health care operations purposes, treatment may not be conditioned on my agreement to sign an authorization (unless I am receiving care solely to create protected health information for disclosure to a third party [42 CFR § 164.508(b)(4)(iii)].
- Communications resulting from this authorization will reveal that I received services at OPTIONS Family & Behavior Services.
- Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires OPTIONS to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by the HIPAA rules.

_____
Today's Date

_____ _____
Signature of Client Signature of Parent/Guardian (if applicable)

_____ _____
Signature of Staff Signature of Parent/Guardian (if applicable)