NORTHWESTERN COUNSELING & SUPPORT SERVICES

Parent Child Center

| Patient Information | Referring Provider Information |
|---|---|
| Name: _____ | Provider Name: _____ |
| Preferred Name: _____ | Practice Name: _____ |
| DOB: _____ | Practice Address: _____ |
| Parent/Guardian Names: _____ | Practice Phone Number: _____ |
| Address: _____ | Practice Fax Number: _____ |
| Best Contact Number: _____ | Provider/Practice Email: _____ |
| Email Address: _____ | |
| Insurance Carrier: _____ | |
| Policy # _____ Group # _____ | |
| Policy Holder's Name: _____ | |
| Policy Holder's DOB: _____ | |

☐ I, the referring provider, understand that neither NMC nor NCSS is not designed for urgent assessment of children and adolescents with acute safety concerns. Please contact your local Community Mental Health Center if needed for any urgent safety concerns.

WHAT IS THE MAIN CONCERN YOU WOULD LIKE ADDRESSED WITH THIS CONSULTATION?

_____
_____
_____
_____

PLEASE LIST ANY OTHER TREATMENT PROVIDERS/AGENCIES INVOLVED:

_____
_____
_____
_____

**PLEASE SEND THIS COMPLETED FORM, ALONG WITH THE RELEASE OF INFORMATION, TO OUR FAX: 802-752-1993.** Any questions can be directed to: NMCDevelopmentalClinic@nmcinc.org, 802-752-1992, NMC Developmental Clinic, Cobblestone, Suite 204, 133 Fairfield St, St. Albans, 05478

☐ Pertinent Medical Records (must have documented developmental concerns)

☐ Completed ROI from PCP and any other pertinent providers (Speech Therapy, etc)

REFERRING PROVIDER SIGNATURE: _____ DATE: _____TIME: _____

NMC
Northwestern Medical Center

Health Information Management
Phone: 802-524-1288
Fax: 802-524-1030
Email: HIM@NMCINC.ORG

# AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

_____ _____
**Patient Name** **Date of Birth**

**Medical Record #:** _____ **Account #:** _____

1. I hereby authorize **NMC PEDIATRIC DEVELOPMENTAL CLINIC** to:
   _____ obtain my information from
   _____ release my information to:

   □ Healthcare Provider(s)
   □ Childcare Provider(s)
   □ School(s): Specify school district_____
   □ Childcare Community Support Agency Staff
   □ Care Team Member (example: PT, OT, SLP Providers specific to this patient)
   □Other:_____
   □Other:_____
   □Other:_____

**2.To communicate with and disclose to one another the following information (check all that apply)**
   □ Referrals, intakes, screenings, assessment and/or evaluation records
   □ Physical health records
   □ Individual Education Plan/School Records
   □ Other records (pertaining to services checked above)

   Other (specify): _____

3. **There are no limitations** placed on dates, history of illness or diagnostic/therapeutic information, including any treatment of alcohol, drug, HIV/AIDS, mental health, behavioral health or psychiatric and/or psychotherapy notes or treatment.

**THE SIGNER MUST INITIAL THIS CLAUSE:_____ OR QUALIFY #3 ABOVE**

4. The above information is released for the following purpose and that purpose only:
   □ To determine services necessary for me, my child, or my family
   □ To coordinate services across all childhood providers
   □ To consult with others as needed
   □ Other:_____



* A U T H *

**Revocation Process:** I understand that I must place my request in writing to the Privacy Officer; I can revoke this authorization at any time. However, I understand that a health care organization cannot take back information that has already been released in response to this Authorization. I understand that the revocation of this Authorization will not apply to my insurance company whenever my insurer has a legal right to contest a claim under my policy.

This authorization **will expire one (1) year from the date of my signature** or as otherwise specified by date, event, or condition as follows:

_____.

5. **Right to Copy/Voluntary Disclosure:** I know that I have the right to receive a copy of this Authorization after I sign it and that authorizing the disclosure of my health information is voluntary.

6. **Health Plan/Insurance Issuers-Conditions:** I need not sign this form to receive treatment, to have my treatment paid for by my insurer, for enrollment in a health plan, eligibility for its benefits or if I am authorizing my information to be released to an insurance company. I have been advised by my insurer of my rights and the consequence to me should I refuse to sign this Authorization.

7. **Photocopy:** I further authorize that a photocopy of this authorization form will be fully acceptable as an original and that Northwestern Medical Center may deny the release of protected health information if it has reason to believe:

(1) this authorization has been altered or
(2) is not a true and accurate authorization initiated by the patient

**REDISCLOSURE:** I understand that authorizing the disclosure of this protected health information is voluntary. I understand that any disclosure of information carries with it the potential of unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

**SIGNER MUST INITIAL THIS CLAUSE: _____**

_____ _____

**Patient's Signature** **Date**
(*Photo identification or verification of signature is required*)

_____ _____

**Signature of Legal Representative/Relationship to Patient** **Date**
*(Photo identification may be required*)

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*Department Use Only:*

☐ Photo ID from patient/legal representative verified.

Information released by: _____ on date: _____



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