SUMMITSTONE HEALTH PARTNERS

PRIMARY CARE REFERRAL FORM
(PSYCHIATRIC, ADDICTION MEDICINE, AND CLINICAL SERVICES)

REFERRAL INFORMATION:

Referring Staff Member on Behalf of the PCP:	Referring Staff Role:
Referring Physician/Practice:	Referral Date:
Referring Physician/Practice Contact Information:	
Preferred Method for Follow-Up Communication: ☐ Email (Please add preferred email address): ☐ Fax (Please add fax number): ☐ Telephone (Please add preferred telephone number):	

CLIENT INFORMATION:

Client Name:	Client Date of Birth:
Client Medicaid Number:	
Client Telephone Number and Email Address:	
List any special needs this client has, or recommendations to share that would help SummitStone to engage this client.	

REFERRAL TYPE (CHECK ALL THAT APPLY):

☐ Therapy Only ☐ Psychiatric ☐ Addiction Medicine	Is this referral for: ☐ A Single Brief Consultation (up to 3 session) ☐ A Short-Term Stabilization and Return to PCP ☐ Transition and Ongoing Care at SummitStone

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PLEASE INCLUDE IN YOUR REFERRAL:

☐ Most recent concern(s):	
☐ Medication(s) prescribed, includingpsychiatric medications (feel free to attach most recent medication lists):	
☐ Most recent medical progress note,making note of any recent inpatient or emergency psychiatric care (as indicated on Release of Information 'ROI' form):	
☐ Any integrated behavioral healthdocumentation	
☐ A signed ROI forSummitStone, if available (see the next page)	

Email completed form and documentation to:
Referrals@SummitStoneHealth.org

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RELEASE OF INFORMATION (ROI)

PHONE: (970) 494-4200 • FAX: (970) 493-9889 (MEDICAL RECORDS) • 4102 S. TIMBERLINE RD., FORT COLLINS, CO 80525

www.summitstonehealth.org

Client's Name: Click here to enter text	**Client's Date of Birth:** Enter date	**Client's MRN:** Click to enter text

I authorize SummitStone to release/receive my information as follows:

Name of Recipient: Click here to enter text	**Recipient Organization:** Click here to enter text
Recipient Address/Email:	
Recipient Phone/Fax: Click here to enter text	**Recipient Relationship to Client:** Click here to enter text

The purpose of the disclosure is (please check all that apply):

☐ Client requested letter	☐ Coordination of Care	☐ Communicate therapy results and/or attendance
☐ Obtain/maintain housing	☐ Continuity of Care (ongoing)	☐ Obtain/maintain employment/supportedemployment
☐ Other (describe): Click here to enter text		

I authorize the release of the following information (please check all that apply):

☐ Diagnosis	☐ Attendance Dates/Scheduling	☐ Intake
☐ Medications	☐ Demographics	☐ Treatment Plan(s)
☐ Lab Reports/UABA Results	☐ Housing/Employment Notes	☐ Discharge Summary
☐ Psychiatric Evaluation	☐ Psychiatric Progress Notes	☐ Therapy Progress Notes*
☐ Other (describe): Click here to enter text		

**These notes may contain sensitive health information and may require a meeting with therapist prior to release.*

- I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law (HIPAA and 42 CFR Part 2). This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time except to the extent SummitStone has already acted in reliance on it. I understand and agree that this release form may be sent to the agencies and persons identified above. Regarding information not pertaining to a substance use disorder, a disclosure authorized by me carries with it the potential for re- disclosure by the recipient and that federal privacy laws may no longer protect that information.
- SummitStone may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this Authorization.I will receive a copy of this Authorization for my records.
- This consent to release information expires two (2) years from date of signature.

_____ _____

Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client. Date of Signature

_____ _____

Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including authority to act for client. Date of Signature

AUTHORIZATION TO REVOKE RELEASE

*By signing below, you are **revoking** permission for SummitStone to release any of the information previously permitted.*

_____ _____

Signature of Client, Parent/Guardian (for client under 15 years of age) or Authorized Representative, including authority to act for client. Date of Signature