HARMONY
Mental Health

Release of Information

Client name:		Client DOB:	

I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164, Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.

I understand that my records may contain information regarding my mental health, substance use or dependency, or sexuality, and also may contain confidential HIV/AIDS – related information. I further understand that by signing below, I am authorizing the release or exchange of these records to the parties named below. I understand that this authorization is voluntary and that I may revoke this authorization at any time by notifying Harmony Mental Health in writing, but if I do, it will not have any effect on any actions Harmony Mental Health took before it received the revocation.

I hereby authorize Harmony Mental Health or designated staff to (check all that apply):

☐Obtain records/information from:
☐verbally:

☐ Release records/information to:
☐ in writing:

Contact Name: _____ Agency: _____

Phone: _____ Fax: _____

The information to be disclosed is:

☐ Mental health status report
☐ Progress notes / Treatment plan
☐ Chemical dependency evaluation
☐ Case management notes
☐ Family / social history
☐ Court and probation records
☐ Psychological / psychiatric / intellectual assessment
☐ Verification of program engagement / participation
☐ Summary of presenting problem(s), diagnostic findings, treatment, discharge and summaries
☐ Medical reports / health history
☐ School reports
☐ Other (specify): _____

For the purpose of: (please specify why information is being disclosed):

☐ Evaluation report ☐ Treatment planning ☐ Record completion
☐ At the request of the individual ☐ Other: Care coordination

I understand that this authorization will expire on: _____ or within one year from the below date, whichever is earlier.

Signature of individual authorizing release	Date
Signature of witness (if required)	Date
Signature of parent/guardian (if required)	Date

HARMONY
Mental Health

Psychological Evaluation Referral Form

CLIENT DEMOGRAPHICS

Referring Clinician
Clinician NPI
Client ID
Client Name
Client DOB
Client Age
Client Gender
Parent/Guardian

Diagnosis

INSURANCE INFORMATION

Insure
Is this the initial prior authorization?
Date of diagnostic assessment
Who is referring client for psychological evaluation?

ASSESSMENT INFORMATION

(To be completed by referring clinician)
If client is comfortable with you doing so, please send copy of most recent diagnostic assessment or other relevant data.

Reason for testing: (Note: Please indicate what *specific clinical questions* will be answered through psychological evaluation that cannot be answered through comprehensive diagnostic interview, gathering of collateral information, and record review alone.)

Why is psychological evaluation being pursued at this time (e.g., have previous/current treatments and/or providers had minimal success, what treatments have been tried, is documentation needed for other services)?

How will the results of psychological evaluation facilitate treatment goals and/or provide information beyond that currently available?

Please explain any academic issues if present:
Special education?
Is this service court ordered?

List current and past medical concerns/issues that may be relevant: Click here to enter text.
List all medications:

History of substance use (describe substance use history, last use, age at first use, and if applicable, treatment history, and outcome of treatment)

Substance	Age of first use	Frequency /duration	Notes

Other:

Psychosocial and environmental concerns:

Has previous testing been completed: (If yes, please obtain previous evaluation documentation for review *before* referring for assessment.)

Does the client require supervision/ observation during computer-administered testing? If so, why?

Does the client require an interpreter during appointments?

AREAS OF NEED
(To be completed by referring clinician)

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ADMINISTRATION INFORMATION
(To be completed by assessing clinician)

BATTERY DESIGN

Measure	Reason	Billing Code	Quantity

Supervisor Signature & Date:

_____ _____

Date

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AUTHORIZATION INFORMATION

Authorization request submitted on:
Billing Specialist Signature & Date:

Betsy Vincent _____ Date _____

Units Allowed with Authorization

90791: #
96130: #
96131: #
96136: #
96137: #

Authorization approved on:
Billing Specialist Signature & Date:

Betsy Vincent _____ Date _____

STOP TESTING & REQUEST ADDITIONAL UNITS IF ABOVE UNITS ARE EXHAUSTED. ADDITIONAL AUTHORIZATION MUST BE REQUESTED FOR ADDITIONAL UNITS

Summary of Coding

Quantity	CPT
# of units	90791
# of units	96130
# of units	96131
# of units	96136
# of units	96137