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 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:
☐ in writing:

☐ Release Records/information to:

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

Adult DBT Group Referral Form

CLIENT DEMOGRAPHICS

Referring Clinician: _____ Clinician NPI: _____

Client Name: _____ Preferred Name _____

Client DOB: _____ Client Age: _____

Client Phone Number: _____ Client Gender: _____

Diagnosis:

REFERRAL SOURCE INFORMATION

Skip if the referral source is the same on the attached release of information.

Contact Name:			
Agency:			
Phone:		Fax:	

INSURANCE INFORMATION

Insurer:

Insurance ID:

Insurance Group:

Authorization Required for Assessment (Yes/No):

Date of Diagnostic Assessment*:

***Please be sure to include the most recent DA with referral.**

REFERRAL INFORMATION

(To be Completed by Referring Clinician)

Reason for Referral:

Psychosocial and Environmental Concerns:

Is the client currently seeing a Mental Health Provider? Who?

List All Known Medical Concerns/ Issues:

List All Medications:

History of Substance Abuse (describe substance abuse history including substance use, last use, age at first use, treatment history, and outcome of treatment)

HARMONY
Mental Health

Substance	Age of first use	Frequency /duration	Notes
Other:			

Please check the following criteria relevant to the client:

- ☐ **18 years or older**
- ☐ **Experiencing a mental health crisis**
- ☐ **Intentional Self Harm (suicidal & non-suicidal)**
- ☐ **Diagnosis of borderline personality disorder**
- ☐ **Multiple mental health diagnoses and is exhibiting behaviors characterized by impulsivity or intentional self-harm behavior and is at significant risk of death, morbidity, disability, or severe dysfunction across multiple life areas**
- ☐ **Decompensation of mental health symptoms**
- ☐ **Risky impulsive behavior**
- ☐ **At risk for a need for a higher level of care, such as hospitalization or partial hospitalization**
- ☐ **Currently having chronic self-harm thoughts or urges (suicidal or non-suicidal) although the person has managed to not act on them**

Please indicate areas of functional impairment relevant to the client:

- ☐ **Mental Health Services**
- ☐ **Use of Drugs and Alcohol**
- ☐ **Medical**
- ☐ **Vocational**
- ☐ **Educational**
- ☐ **Dental**
- ☐ **Housing**
- ☐ **Transportation**
- ☐ **Financial**
- ☐ **Self-Care and Independent Living Capacity**
- ☐ **Social (including the use of leisure time)**
- ☐ **Interpersonal (including relationships with family)**