Human Resources Center Referral

| Services: Mental Health Assessment/Therapy Substance Use Assessment/Therapy | | |
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| Reason for Referral: | | |
| Please have client/guardian sign below, then fax to HRC at: 463-1899, Attn: Johanna Westin HUMAN RESOURCES CENTER OF EDGAR & CLARK COUNTIES P.O. Box 1118, Paris, Illinois 61944 is hereby authorized to: | | |
| Name of Referring Provider: | | |
| Horizon H | lealth, Paris, | IL 61944 |
| Information concerning: (Full name of individual for | whom information is | Birthdate:s requested/released) |
| | | |
| Address: | | Phone: |
| Address: Mental Health, Developmental Disabilities, and | commendations | g Abuse Information: |
| | commendations tes | g Abuse Information: ⊠Attendance/Progress Reports ⊠Closing/Discharge Summary |
| Mental Health, Developmental Disabilities, and ☐Assessment/Evaluation Results & Red ☐Psychiatric Evaluation & Progress Not | commendations tes conditions and | g Abuse Information: ☑Attendance/Progress Reports ☑Closing/Discharge Summary medications |
| ✓ Mental Health, Developmental Disabilities, and Massessment/Evaluation Results & Red Psychiatric Evaluation & Progress Not ✓ Other Information (describe): Medical history, Method of release: ✓ Photocopies ✓ Verbal [| commendations tes <u>conditions and</u> Written Mater | g Abuse Information: ☑Attendance/Progress Reports ☑Closing/Discharge Summary medications |
| ✓ Mental Health, Developmental Disabilities, and Massessment/Evaluation Results & Red Psychiatric Evaluation & Progress Not ✓ Other Information (describe): Medical history, Method of release: ✓ Photocopies ✓ Verbal [| commendations tes conditions and Written Materioordination and ce. The person sign to be disclosed. The information and the | g Abuse Information: Attendance/Progress Reports Closing/Discharge Summary medications ial Facsimile copies Other: professional consultation. ing did so freely and with full knowledge and understanding. The person further understands that a refusal to consent to in without further consent or when mandated by law. There |
| Mental Health, Developmental Disabilities, and Sasessment/Evaluation Results & Recompsychiatric Evaluation & Progress Note: Other Information (describe): Medical history, Method of release: Sphotocopies Sverbal Service For the purpose of: Referral for care, care controlled to the purpose of the purpose of the information the release of the above information will prevent the disclosure is the right to revoke this consent at any time. IF NOT PREVICAST EXPIRATION DATE NOTED. | commendations tes conditions and Written Materioordination and ce. The person sign to be disclosed. The information and the | g Abuse Information: Attendance/Progress Reports Closing/Discharge Summary medications ial Facsimile copies Other: professional consultation. ing did so freely and with full knowledge and understanding. The person further understands that a refusal to consent to my without further consent or when mandated by law. There D IN WRITING, THIS AUTHORIZATION WILL EXPIRE ON |
| Mental Health, Developmental Disabilities, and Sasessment/Evaluation Results & Recompsychiatric Evaluation & Progress Note: Other Information (describe): Medical history, Method of release: Sphotocopies Sverbal Service For the purpose of: Referral for care, care controls to the person has the right to inspect and copy the information the release of the above information will prevent the disclosure the right to revoke this consent at any time. IF NOT PREVIAST EXPIRATION DATE NOTED. | commendations tes conditions and Written Materior and condination and to be disclosed. The person sign of the information of the informatic viously revoke | g Abuse Information: Attendance/Progress Reports Closing/Discharge Summary medications ial Facsimile copies Other: professional consultation. ing did so freely and with full knowledge and understanding. The person further understands that a refusal to consent to in without further consent or when mandated by law. There D IN WRITING, THIS AUTHORIZATION WILL EXPIRE ON |

NOTICE TO RECEIVING PARTY: UNDER THE PROVISIONS OF THE ILLINOIS MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES CONFIDENTIALITY ACT, YOU MAY NOT REDISCLOSE ANY OF THIS INFORMATION UNLESS THE PERSON WHO CONSENTED TO THIS DISCLOSURE SPECIFICALLY CONSENTS TO SUCH REDISCLOSURE.

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIALITY RULES (42 CFR PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION IS **NOT** SUFFICIENT FOR THIS PURPOSE. THE FEDERAL RULES RESTRICT ANY USE OF THE INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.