TJocelyne Counseling
& Consulting Group
425 Pleasant Street, 1Fl. Brockton,2301
Fax 888-506-6021 or Intake@tjocelyne.org

Psychiatry Referral Form

Date of Referral: _____ Referral Source: _____

Name: _____ SSN: _____

Gender: _____ Age: _____ DOB: _____

Parent's Name: _____

Address: _____

City: _____ Zip:_____ Parish: _____

Phone #: _____ Cell #: _____ Other #: _____

Medicaid: ☐ Yes ☐ No #: _____

Diagnosis Code: _____

Current Mental Health Services: ☐ No ☐ Yes Agency: _____

***_**Disclaimer: you must agree to seeing a clinician at our practice/clinic to receive med management services**_**

			Comments:
Previously evaluated by a psychiatrist	☐ No	☐ Yes	_____
Did you have difficulty finding psychiatry services?	☐ No	☐ Yes	_____
Currently taking any mental/behavioral health medications?	☐ No	☐ Yes	_____
Past history of taking mental / behavioral health medication?	☐ No	☐ Yes	_____
Substance Use Issues?	☐ No	☐ Yes	_____
Legal / FINS Issues?	☐ No	☐ Yes	_____

Comments – Reason for Referral

(Need to include specific symptoms, behaviors, presenting issues)

_____

Consent Forms must be attached for: ☐ **PCP/Pediatrician** ☐ **School** ☐ **Current & Past MH Providers**
(to include hospitals, inpatient)

For Office Use Only: Scheduled Appointment Date: ______________________________________

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

TJOCELYNE COUNSELING CENTER

508-580-0364 EMAIL:INTAKE@TJOCELYNE.ORG FAX 888-506-6021

425 PLEASANT STREET, FIRST FLOOR, BROCKTON, MA 02301

I,____ DOB:_________________

hereby give my permission to **THE TJOCELYNE COUNSELING CENTER**, to release or request from a third party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following:

To/From: ____

First and last name, phone, and address of person(s)

The type of information to be disclosed/requested is as follows:

To Be Released * *from TJOCELYNE COUNSELING*

____Treatment Plans

____Process Notes

___ Health/Medical Records (if applicable)

____Letter(s) of Progress

____Bio Psychosocial Evaluation/Assessment (if applicable)

__X Verbal Communication

____Other (Specify): ______________________________

To Be Requested * *from third parties*

____Treatment Plans

____Process Notes

_X__Health/Medical/Academic Records

_x__Psychological/Psychiatric Evaluations/Assessments

____Court Documents

__X Verbal Communication

_x__Other (Specify): medication list

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **TJOCELYNE COUNSELING CENTER**.

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and TJOCELYNE COUNSELING CENTER will not base my treatment or payment whether or not I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge).

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or **TJOCELYNE COUNSELING CENTER** will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **TJOCELYNE COUNSELING CENTER** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire when the client is discharged from the current episode of care (treatment has been completed, the client rejects/declines/drops out of treatment, is referred elsewhere, moves, or in the case of the client's death.) This agreement is subject to revocation in writing at any time.

Release:

____

Signature Client/Next of Kin/Guardian Date

____

Clinician Signature/Credentials Date

Request:

____

Signature Client/Next of Kin/Guardian Date

____

Clinician Signature/Credentials Date

TJocelyne Counseling & Consulting all rights reserved. Last Revision 3/29/2019.