CONSENT FOR REFERRAL TO BEHAVIORAL HEALTH SERVICES

I (Parent/Guardian), ____ authorize:

____ (School/Agency to make the disclosure)

to release the information described below to (Agency receiving the information):

Select preferred provider:

- The Guidance Center
  2187 N Vickey St
  Phone: (928) 527-1899
  Fax: (928) 714-5365
  mmase@tgcaz.org
  (TGC serves AHCCCS and some Private insurance)

- Southwest Behavioral & Health Services
  1515 E. Cedar Ave. #B-4
  Flagstaff, Arizona 86004
  Phone: (928) 779-4550
  www.sbhservices.org
  (SBHS serves AHCCCS and some Private Insurance)

Regarding (child's name): ________________________________ DOB: ____________

Purpose for disclosure: (Referral, outreach, initial coordination of care for access to services, eligibility assistance)

____

By signing this authorization, I consent to referral information including name, contact information, eligibility and purpose of referral, and service needs to be provided. The receiving agency will provide outreach to referral sources and parent/guardian to review eligibility and services options. The receiving agency is authorized to verify enrollment or provide reasons services were declined back to referral source.

Purpose is to coordinate referral and outreach for access to care. Any further disclosure would require additional consent obtained as part of the agency's intake process.

I consent for the provider to contact me: ____

Phone or other contact information: ____

Preferred contact times (if applicable): ____

Health Plan information (if known/applicable): ____________________________________

Rights:

- I understand that I may refuse to sign this authorization and my refusal will not affect the services my child receives, payment, or eligibility for benefits.
- I can revoke this authorization at any time by sending a written note to the referring agency/person. I understand that the request to withdraw my consent will be valid as soon as received but will not apply to information previously disclosed.

- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws.
- I have a right to receive a copy of this authorization.

This consent will expire on ______________________________________ or one year from signature date.

Parent/Legal Guardian Name: ____

Signature: ____ Date: _______________

Staff Name/Witness: ____

Signature: ____ Date: _______________

Title/Credentials: ____

Notice: *Alcohol and drug abuse patient records are protected by Federal confidentiality regulations (42 CFR part 2). The Federal regulations 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 regulations restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Communicable disease related information, pursuant to this release, cannot be re-disclosed without specific written authorization (ARS 36-664)*

I revoke this authorization on: ____