Mental Health PARTNERS
Healthy minds, healthy lives, healthy communities

MHP Referral Form

303-443-8500
720-406-3606 (Fax)
Admissions@mhpcolorado.org

Date:

Referral Source Information

Referral Source:	Would you like MHP to coordinate your care with this aagency/individual? If yes, please be sure to fill out a MHP Authorization to Release Information Form. YES ☐ NO ☐
Contact Person:	
Contact's Info:	

New Client Information - people who need services are not prevented from seeking or receiving care due to their ability to pay or location of residence.

First, Middle, Last Name:			
Date of Birth:	Social Security #:		
Primary Language:	Is a translator needed? YES ☐ NO ☐		
Legal Gender:	Gender Identity:		
Street Address:	City:	State:	Zip Code:
Phone #:	Is it alright to leave a message on this number? YES ☐ NO ☐		
Other Phone #:	Is it alright to leave a message on this number? YES ☐ NO ☐		
Additional Contact Information (e-mail address, etc.):			

Emergency Contact (*Required for persons under 18)	Full Name: Relation to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐
Primary Caregiver (*Required for persons under 18)	Full Name: Relation to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐
Mental Health Decision Maker (*Required for persons under 18)	Full Name: Relation to Client:	Phone #: Is it alright to leave a message on this number? YES ☐ NO ☐

Financially Responsible Party (if other than yourself):	Full Name:	Relation to Client:		
	Phone #:	Is it alright to leave a message on this number? YES ☐ NO ☐		
	Street Address:	City:	State:	Zip Code:

Insurance Information *(see financial assistance information if minimal or no insurance)*

Insurance #1	Policy Holder Name:	DOB:	Relation:
	Company:		
	Company Phone #:		
	Policy #/Member ID:		
	Group Number:		
	Group Name:		
Insurance #2	Policy Holder Name:	DOB:	Relation:
	Company:		
	Company Phone #:		
	Policy #/Member ID:		
	Group Number:		
	Group Name:		

***Please turn page over**

Income Information

MHP offers a financial assistance program. Persons who qualify will be eligible for a $5 monthly fee.** ***In order for MHP to determine whether or not you may be eligible for a reduced fee under certain circumstances we need to gather some basic financial information.

Size of Household (please include yourself, spouse and any dependent children): ☐

Gross Household Income (please indicate whether this number is annual, monthly, etc.): ☐

1. Are you currently having any thoughts of suicide or self-harm? Yes ☐ No ☐

2. Are you currently having any thoughts of homicide or harm to others? Yes ☐ No ☐

3. Are you hearing or seeing things others do not appear to be hearing or seeing? Yes ☐ No ☐

****If you are currently experiencing any of the issues above and would like to speak to someone right away, please contact our 24/7 emergency team at 303-447-1665. You are also welcome to drop in any time of day or night 7 days a week at 3180 Airport Road, Boulder, CO. 80301.***

If yes to questions 1, 2 or 3, please provide more details below:

☐

In a couple of sentences, please describe the reason for seeking mental health and/or substance abuse services:

☐

4. Have you ever used drugs intravenously or injected? Yes ☐ No ☐

5. Have you ever used Opioids? Yes ☐ No ☐

6. Do you have dependent children under the age of 18, and are you currently using drugs or alcohol? Yes ☐ No ☐

7. Have you been hospitalized for mental health services in the past 30 days? Yes ☐ No ☐

8. Are you pregnant? Yes ☐ No ☐

If so, when is your due date? ______________________

9. Do you have any obstacles to transportation that would prohibit you from going to a MHP location? Yes ☐ No ☐

10. Which city would you prefer to receive services? Please Circle: **Boulder** **Longmont** **Broomfield** **Lafayette**

**When you send this online referral form to Mental Health Partners through e-mail, the sensitive information you have put into this document will not be secured until it reaches our e-mail inbox. There is some risk that any information in this e-mail may be disclosed to, or intercepted by, unauthorized third parties which are commonly referred to as hackers. If you would prefer, you may hand deliver or mail this form to Admission and Referral, Mental Health Partners, 1333 Iris Ave, Boulder, CO 80304 or fax to 720-406-3606.*

MHP Staff - Please check one: Send Information Now______ Request Information Now______ File for Future/As Needed Use______ One time release only_____

CID#__________________________

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MENTAL HEALTH PARTNERS

1333 Iris Avenue, Boulder, CO 80304-2296 Phone 303-247-8791 FAX 303-484-4485 (Clinical Records)

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Client Name:____ Client's Date of Birth: ________________

(Include client's AKA, maiden name, etc. of person receiving services at MHP)

I authorize that information may be exchanged between the following named individual or entity and Mental Health Partners (MHP):

*Name: ____ Relationship to Client: ________________

Address/e-mail: ____ Phone: ____________________________

____ FAX: _____________________________

☐ *Check here if this is for your Primary Care Physician*

☐ *Check here if you want to authorize release of your substance use disorder treatment information to all your past, present and future treatment providers as a general designation authorization*

***If using this form to release your SUBSTANCE USE DISORDER TREATMENT information to anyone who is NOT 1) providing treatment, or 2) paying for treatment <u>you must indicate a specific individual (not an agency or entity) to receive that information by their first and last name</u>.**

The purpose of the disclosure is: (It is required to check one of the purposes below or provide a specific purpose)

______ Client requested letter ________ Coordination of care ______ Communicate about therapy results and/or attendance

______ Obtain/maintain housing ________ Obtain/maintain benefits ______ Obtain/maintain employment/supported employment

Other (Please Specify): ____

____

____

Please check any items below to release the following information:

_______ **All my physical and mental health treatment records, Including HIV/AIDS (unless restricted below)

_______ **All my substance use disorder treatment (drug and alcohol) records (this can be restricted below)

_______ Diagnosis

_______ Medications

_______ Progress Notes

_______ Treatment Plan(s)

_______ Psychological Evaluation

_______ Psychiatric Evaluation

_______ Emergency Services Reports (§ 27-82 commitments)

_______ Psychiatric Progress Notes

_______ Employment

_______ Benefits

_______ **HIV/AIDS

_______ Demographics

_______ **Drug and Alcohol Evaluations

_______ Physical Examination

_______ Information provided by client to receive benefits

_______ Service Attendance Dates

_______ Lab Reports

_______ Patient Assistance Program (PAP) Information

_______ Intake/Admission Information

_______ Information needed to complete application for organization

_______ Discharge Summary

_______ Housing

_______ Education

_______ Other (Please Specify additional items to release) ____

____

I understand that information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse (*protected by Federal Law, 42 CFR, Part 2), and psychological or psychiatric conditions, and any other information in your medical record **unless restricted as follows**: ____
____

Once information is disclosed pursuant to this signed authorization, I understand that the general federal privacy law (45 C.F.R., Parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice to the MHP Privacy Officer or his/her designee. If not revoked earlier, this release/authorization will expire **two years** from the most recent date signed. I hereby release the above parties from liability that may result from furnishing this information. A copy of this release/authorization may be utilized with the same effectiveness as an original. I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment at MHP.

MHP does not recommend electronic format (such as e-mail, texting with clinical staff) as a means of communication with MHP employees. There is some risk that any protected health information that may be contained in such e-mail or text may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, you are acknowledging that electronic media is not secure and you are releasing MHP from any liability relating to unauthorized disclosure of PHI contained in electronic media correspondence. Charges for copies may apply: $16.50 for up to 10 pages; $.75 for pages 11-40; $.50 for each additional page; $10 for electronic format.

(***Optional***) I restrict the dates for which my records can be released to between: ___/___/_____ and ___/___/______.

____ _________________________________
Signature of Client, Parent/Guardian (for client under 15 years of age), or Authorized Representative, including your authority to act for client — Date of Signature

_____________________________________ _________________________________
Signature and Date to Extend Request — Signature and Date to Extend Request

_____________________________________ _________________________________
Signature and Date to Extend Request — **Signature and Date to Revoke Authorization**

***NOTICE TO RECIPIENTS OF DRUG AND ALCOHOL TREATMENT PROGRAM INFORMATION: This information has been disclosed to you from records protected by Federal Law (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.