LifeWorks NW Referral Form

Please complete this form and fax to—ATTN: Intake 503-629-8517 or email it to intakereferrals@lifeworksnw.org. If you need assistance or you don't receive a response within two business days, please contact our intake department at 503-645-9010.

IMPORTANT: LifeWorks NW's medical records are held under HIPAA restrictions. We require a Release of Information Authorization if you are not considered a covered entity. If you are not a covered entity, please attach the required authorization or use the one that is included. Otherwise**, we will not be able to complete this referral or be able to confirm the engagement.**

Today's Date:_____

Referral Information

Contact regarding this referral (referring person/patient/other):_____
Name:_____
Phone number:_____
Fax number:_____
Email:_____
Agency: _____
Services for (self, client, child, spouse/partner, parent, other):_____
Type of service requesting:_____
Preferred location:_____
Reason for referral:_____

Client information

Client's First & Last Name:_____ Preferred Name:_____
Client's DOB:_____
Gender:_____
Client's phone number:_____
Client's alternate phone number:_____
Client's email address:_____
Client's address:_____
Client's city:_____
Client's state:_____
Client's ZIP code:_____
Preferred language:_____
If the client is under the age of 18, the guardian's full name:_____
Phone number: _____ Do they reside in a group home? Yes or no: _____
Name of Group/Care home: _____

NOTE: Please include guardianship authorization with this referral

Insurance Information

Policy Name:_____ Policy Number:_____
Client's PCP:_____ Client's PCP clinic:_____
Client's PCP phone:_____ Client's PCP:_____
FAX:_____

LIFEWORKS NW

ROIA _____

EFFC. DATE_____

Authorization to Use and Disclose Protected Health Information

Unless revoked, this authorization will remain in effect agency-wide and program-wide for the duration of my treatment and thirty days after discharge for coordination of care or until: _____

First and Last Name: _____ Date of Birth: _____

1. Person/Organization to disclose information to _____

   Phone: _____ FAX: _____ Address: _____

2. Information will be used on my behalf to both release and receive information for the following purposes:

   ☐ Evaluation Review ☐ Treatment referral

   ☐ Coordination of Care ☐ All of above

   ☐ Treatment planning

   In accordance with HIPAA 42CFR, please list any specific information you would like to disclose _____

3. By **initialing** the spaces below, I authorize the release of the following protected medical records:

   ► _____ Disclose alcohol and drug information
   Initial here

   ► _____ Disclose mental health and/or medication information
   Initial here

   ► _____ Disclose HIV/AIDS information
   Initial here

4. Federal or state law requires that HIV/AIDS, mental health, drug/alcohol, or genetic testing information not be re-disclosed. I understand that this information may be shared via phone, fax, mail, email, in written form, or in person. I understand that I may revoke (i.e., take back) this authorization either in writing or verbally at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purpose described on this form. If LifeWorks NW has already used or disclosed information because of this authorization, that cannot be undone. This information has been disclosed from Lifeworks NW whose confidentiality is protected by federal law. Federal regulation (42 CFR, Part 2) prohibits you from further disclosing it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. 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.

_____ _____

Signature of client or guardian Date of signature

_____ _____

Relationship to the client if signed by guardian Reason client is unable to sign.