LUTHERAN Community Services NORTHWEST

ONLINE REFERRAL - Outpatient Counseling
PHONE: 509-747-8224 | FAX: 509-747-0609
IntakeSpokane@lcsnw.org

Name of client:			Date of referral:
Preferred Language:	Ethnicity:		Date of Birth:
Street Address:		Gender:	Age:
City:	State:	Zip:	County:
Client Phone:		Client Phone 2:	
If client is youth, lives with: Biological Family ☐ In Home Dependency ☐ Adopted ☐ Foster Care ☐ Other ☐			
Person making referral:		Referral contact phone:	
Agency/relationship to client:		Referral contact email:	
Purpose of referral/current needs and concerns:			
Insurance Information			
Insurance(s):		ID/group number(s):	
Involved Parents/Caregivers			
Name:		Name:	
Address:		Address:	
Phone:	Email:	Phone:	Email:
Legal Guardian (Custodial parent, caregiver, social worker, power of attorney, etc.)			
Name:		Contact info:	
Is there a parenting plan in place: YES ☐ NO ☐ If yes: Sole Decision Making ☐ Joint Decision Making ☐			
Legal Issues			
Probation: YES☐ NO☐	Diversion: YES☐ NO☐	Protection Order: YES☐ NO☐	Pending Charges: YES☐ NO☐
More info:			
Education Status			
School:	Grade:	Attendance: YES ☐ NO ☐	IEP/504: YES ☐ NO ☐
Primary Care Physician and Medications			
Taking medication: YES ☐ NO ☐		PCP Name and Clinic:	

Directions: Please provide as much information as possible. If you are completing this referral for someone else, we will only be able to confirm that we have received the referral from you. If you want to find out more information about the status of the referral, you will need the client (or legal guardian if they have one) to complete a release of information specifically for mental health care. You may attach a release of information from your agency if you already have one, or you may have the client/ guardian complete LCSNW's release of information found on the next page.

Authorization for Release of Information (ROI)

Client First Name:	Client Last Name:	Client Date of Birth

By my signature below, I hereby give permission for the mutual exchange of information between Lutheran Community Services Northwest (LCSNW) and the organization, entity or individual named below:

Name of organization, entity or individual	Phone number

I authorize disclosure of the following parts of my chart: _____
If I do not specify a part of my chart on the above line, I am authorizing the release of my entire medical record.

Reason for releasing records (check one):

- ☐ To permit continuity or coordination of care
- ☐ To provide support services
- ☐ Other (please specify):

I specifically authorize LCSNW to disclose medical records under this Authorization that may contain substance abuse diagnosis and treatment information about me that is protected by federal regulations governing the confidentiality of substance abuse treatment information (42 CFR Part 2). These records may include, but are not limited to, substance abuse treatment plans, laboratory tests, presence and progress in substance abuse treatment, attendance and compliance with substance abuse treatment, medical history, and discharge summaries.

Additionally, I specifically authorize LCSNW to disclose the following sensitive protected health information about me that may be contained in my medical record: mental health diagnosis and treatment, sexually transmitted disease testing, diagnosis and treatment, and HIV/AIDS testing, diagnosis, and treatment.

I understand I have the right to receive a copy of this signed Authorization form and that a copy will be placed in my file. I understand that I have the right to inspect or copy (may be provided at a reasonable fee) the health information I have authorized to be used or disclosed by this Authorization form.

I understand that once LCSNW discloses my information, LCSNW cannot guarantee that the recipient will not re-disclose my information to a third party. Any such third party may not be required to abide by applicable laws governing the use and disclosure of my information. I understand that, except in limited circumstances, such as research-related treatment or treatment that is solely for the purpose of disclosing information to a third party, I am not required to sign this Authorization in order to receive treatment services at LCSNW, nor will LCSNW condition its treatment services to me on whether I execute this Authorization.

I understand that I have the right to revoke this Authorization at any time by providing a written statement of revocation to LCSNW. I am aware that my revocation will not be effective until received by LCSNW and will not apply to the uses and/or disclosures of my information that LCSNW has made prior to receipt of my revocation statement.

This Authorization will expire one (1) year after of the date of my signature below. I am at least 18 years of age and am competent to contract in my own name, or I am the authorized representative of the client named above. I have read this Authorization before signing below and I fully understand the contents, meaning, and impact of this Authorization.

Signature of client or authorized representative _____ Date:_____

Signed By (write name): _____Relationship if other than client: _____

Notice to recipient of information: 42 CFR part 2 prohibits unauthorized disclosure of these records.