



TWICOUNSELING



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Augusta Fax: 706.228.3233 Vidalia Fax: 912.537.9440
Savannah Fax: 912.234.7884

Date of Referral: _____ Date Received: _____ County _____

Referred by (Name): _____

Referring Agency: _____ E-mail: _____

Contact Numbers (Office) _____ (Cell) _____

Service(s) Requested:

- Mental Health**
- CBAY**
- Other** _____

Consumer Basic Information:

Client Name: _____ Client Case # _____

Date of Birth: _____ Social Security #: _____

Medicaid #: _____ Parent Name: _____

Contacts Numbers: _____

Residential Address: _____

(City) (State) (Zip Code 9 Digits) (County)

Name of School _____

Primary Health Care Physician _____ Phone _____

Mental Health Care Physician _____ Phone _____

Family/Relatives In-Home/Involved in Referral:

Last Name	First Name	Gender	Ethnicity	Relationship to Client	DOB	Placement Code

Presenting Circumstances State the Individual's request and circumstances surrounding the request.



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Name of Individual/Consumer/Patient/Applicant

Date of Birth
IF AVAILABLE

Id # Used by Requesting Org.

ID # used by Releasing

I hereby request and authorize:

(Name of Person or Agency Requesting the Information)

(Address)

To obtain from:

(Name of Person or Agency Holding the Information)

(Address)

The following type(s) of information from my records (and any portion thereof):

For the purpose of: _____

I understand that the federal Privacy Rule ("HIPPA") does not protect the privacy of information if re-disclosed, and therefore request that all information obtained from this person or agency be held strictly confidential and not be further released by the recipient. I further understand that my eligibility for benefits, treatment or payment is not conditioned upon my provision of this authorization. I intend this document to be a valid authorization conforming to all requirements of the Privacy Rule and understand that my authorization will remain in effect for:
(PLEASE CHECK ONE)

- Ninety (90) days unless I specify an earlier expiration date here: _____ (Date)
- One (1) year.
- The period necessary to complete all transactions on accounts related to services provided to me. I understand that unless otherwise limited by state and federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

(Date)

(Signature of Individual/Consumer/Patient/Applicant)

(Signature of Witness) Title of Relationship to Individual

X

(Signature of Parent or Legally Authorized Representative, when Applicable)

Use this Space if Authorization is Withdrawn

(Date Authorization is revoked)

(Signature of Patient or other Legally Authorized Representative, when applicable)