Shalom House

HOME • HEALTH • HOPE

# SHALOM HOUSE ART REFERRAL FORM

NAME: _____DATE:_____

CLASS TITLE:_____

ADDRESS: _____ PHONE: _____

_____ DOB:_____

CIW NAME: _____ ORGANIZATION:_____

PHONE: _____

EMERGENCY CONTACT: _____ PHONE: _____

DO YOU HAVE ANY ALLERGIES OR MEDICAL CONDITIONS WE SHOULD KNOW ABOUT? _____

_____

PLEASE COMPLETE THE ATTACHED RELEASE OF INFORMATION

Please complete all sections of the referral and release. Your referral is not complete without the information. Once we receive your referral, the instructor will contact you to set up an appointment. She will show you the art space and discuss any questions you may have. This is a requirement prior to attendance at your first class.

If you have questions, please call 874-1080 ext. 169.

Please return the completed Application and Release of Information to:

Shalom House, Inc.
106 Gilman St.
Portland, ME 04102
Attn: Tenney Swift
Or Fax: 874-1077

Shalom House
HOME • HEALTH • HOPE

Tel: 207-874-1080
TTY: 207-842-6888
Fax: 207-874-1077
www.shalomhouseinc.org
Mary Haynes-Rodgers, LCSW
Executive Director

# RELEASE/AUTHORIZATION TO USE/DISCLOSE CONFIDENTIAL INFORMATION

**CLIENT NAME:** _____ **CLIENT ID:** _____

**REQUESTED BY:** _____ **DATE OF BIRTH:** _____

***I hereby authorize and request that Shalom House, Inc. release to or obtain from the agency named below the following information or records relating to my treatment.***

**RELEASE TO:**
Person:_____
Agency/Relationship:_____

***Please obtain the following information:***
_ _ Discharge summary
_ _ Psychiatric Evaluation/Assessments
_ _ Treatment Plans (RSP/ISP) and reviews
_ _ Psychosocial history
_ _ Ongoing treatment information
_ _ Housing information
_ _ Other:_____

The purpose of this release is:

_____
_____

**OBTAIN FROM:**
Person:_____
Agency/Relationship:_____

***Please obtain the following information:***
_ _ Discharge summary
_ _ Psychiatric Evaluation/Assessments
_ _ Treatment Plans (RSP/ISP) and reviews
_ _ Psychosocial history
_ _ Ongoing treatment information
_ _ Housing information
_ _ Other:_____

The purpose of this release is:

_____
_____

***Must be initialed by client:***
_☐_ **I DO** _☐_ **DO NOT** want any information released by Shalom House that may be covered by federal rules relating to confidentiality of alcohol or drug abuse treatment released.
_☐_ **I DO** _☐_ **DO NOT** want any information released by Shalom House that may relate to my diagnosis or treatment for HIV infection released.
*This information is protected by Federal Confidentiality rules (42 C.F.R. Part 2)*

- **Right to Refuse:** I understand that I may refuse authorization to disclose some or all of the information in my treatment record, but that such a refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or insurance, or other adverse consequences.
- **Right to Revoke:** I understand that I have the right to revoke this authorization at any time, provided that I do so in writing or verbally.
- **Right to Review:** I understand that I have the right to inspect or copy any information to be used and/or disclosed under this authorization.
- I understand that the above information may be covered by the rules of the Maine Department of Health and Human Services (the "Rights of Recipients of Mental Health Services"). I waive my right to review this information prior to its disclosure.

**THIS RELEASE/AUTHORIZATION WILL EXPIRE ON** _____ **(DATE, TIME, EVENT)**
This Authorization shall be in force and effect until the expiration date noted above, at which time this authorization to use or disclose my protected health information expires.

I choose to willingly release the information stated above. I understand the information will be used only for the purposes indicated and cannot be released to anyone else without my written consent unless otherwise provided for in legislation regarding protected health information and confidentiality of mental health records.

**CLIENT SIGNATURE:**_____ **DATE:**_____
(or Guardian)

**WITNESS:** _____ **DATE:** _____