ALLEVIANT
HEALTH CENTERS™

Phone: (866) 951-HEAL • Fax: (720) 400-7049 • newpatients@alleviant.com

REFERRAL FORM

At Alleviant Health Centers, we seek to collaborate with referring providers to optimize patient care and provide adjunct therapy as needed. Your patient's continuity of care is of the utmost importance to us. Please provide the following:

Patient Name:	
Date of Birth:	
Patient Phone Number:	
Patient Email:	
Referral Diagnosis:	
Referral Provider Name:	
Provider Specialty:	
Provider NPI Number:	
Provider Email:	
Provider Address:	
Provider Phone:	
Provider Fax:	
How did you hear about us?:	
Reason for referral:	

IMPORTANT: Please include with this submission all current diagnoses, current medications and current problem list, as well as face sheet that includes patient insurance information.

SERVICES

☐ Psychiatric Evaluation ☐ Medication Management ☐ Psychotherapy

☐ Ketamine Therapy ☐ TMS ☐ Pain Treatment ☐ Telebehavioral Health

Please fax to (720) 400-7049, or email this fillable form to newpatients@alleviant.com.

AUTHORIZATION TO RELEASE CONFIDENTIAL MENTAL HEALTH TREATMENT INFORMATION

ALLEVIANT HEALTH CENTERS

Patient's Name: _____ Date of Birth: _____

☐ I authorize Alleviant Health Centers To disclose information and records regarding my treatment, medical, and/or behavior health condition, as permitted by this authorization and consistent with applicable law, in either paper, fax, or electronic format, to the following professional health care provider, its physicians, and/or agents:

_____

Provider/Organization Address City State ZIP

Phone Number_____ Fax # _____

☐ To obtain information and records regarding my treatment, medical, and/or behavior health condition, as permitted by this authorization and consistent with applicable law, in either paper, fax, or electronic format, from the following professional health care provider, its physicians, and/or agents:

_____

Provider/Organization Address City State ZIP

Phone Number_____ Fax # _____

The scope of information authorized for released include the following (Patient to initial each item to be disclosed):

_____Assessment
_____Diagnosis
_____Psychosocial Evaluation
_____Psychiatric Evaluation
_____Treatment Plan or Summary
_____Current Treatment Update
_____Medication Management Information
_____Appointment Information
_____Educational Information
_____Presence/Participation in Treatment
_____Nursing/Medical Information
_____Psychological Evaluation
_____Discharge/Transfer Summary
_____Continuing Care Plan
_____Progress in Treatment
_____Demographic Information
_____Other _____

This information may be used or disclosed for the following purposes (Patient to initial each intended purpose):

_____Mental Health Diagnosis and Treatment
_____Coordination of Care
_____Payment
_____Other _____

I understand that (1) my health and behavioral health records are protected from disclosure under federal and/or state law; (2) I may revoke this authorization at any time; (3) this authorization is valid until I revoke it or for three hundred and sixty-five (365) days after I have completed treatment and been discharged, whichever is sooner; (4) once I revoke this authorization, no further information may be released except as authorized or allowed by law; and (5) a file copy is equivalent to the original.

I understand that (1) Alleviant Health Centers, LLC will not condition my treatment on whether I give authorization for the requested disclosure; and (2) failure to sign this authorization may have consequences including the inability to obtain insurance payment authorization for certain therapies including transcranial magnetic stimulation (TMS). I further understand that refusal to sign this authorization may cause Alleviant's staff to have delayed or incomplete ability to understand my medical history, which may impair their ability to properly care for me.

I acknowledge that I was either given a copy of this authorization for my records, or I declined to receive a copy. This authorization was explained to me, and I signed it of my own free will on this, the _____ day of _____, 20_____.

_____ _____

Signature of Patient Signature of Witness

_____ _____

Signature of Parent, Guardian, or Authorized Personal Representative Relationship to Patient

I understand my signature gives permission for release of information that may include, but is not limited to, substance abuse (including alcohol/drug abuse), mental health and HIV-related information including AIDS. The confidentiality of this reocrd is required under 42 CFR Title 42 of the Annotated Code.

_____ _____

Signature of Patient Date