BHG
Behavioral Health Group℠

Address:		
City:	State:	Zip:
Phone:		

Patient Referral Form

Referring Agency:		
Address:		
City:	State:	Zip:
Phone:		
Agency contact:		
Contact phone:	Contact email:	

Patient Name:			
Date of Birth:		❑ Male	❑ Female
Address:			
City:	State:	Zip:	
Phone:	Patient email:		
Reason for Referral:			
Is this referral court ordered?:	❑ Yes ❑ No		

Patient consent to refer:

I am aware of the specific types of information requested to refer me to BHG and I give my consent.

I understand that my records are protected under the Federal Confidentiality Regulations (42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment Patient Records.)

A photocopy of this authorization is acceptable in lieu of the original. Any unauthorized disclosure of patient information is a federal offense. Per Federal Regulations: No disclosure can be made on a form, which does not conform to Federal Regulations and contains the above data. Further if the document appears false, information will not be disclosed until the matter is resolved.

I hereby give my consent to release referral information for use by designated BHG clinical care team members.

Patient signature:	Date:
Staff signature:	Date:

