Western New York Children's Psychiatric Center
Mobile Integration Team Referral
575 Alberta Drive
Amherst, NY
Telephone: 716-832-0720
Fax: 832-5867

Date: _____/_____/_____

Child's Name: _____

SEX: Male_____ Female _____ **DOB: _____/_____/_____**

Child's Address: Street: _____ __ _____

City:_____ **State:_____** **County: _____** **Zip Code:_____**

Telephone #: ( ) _____

LANGUAGE SPOKEN BY CHILD: _____ **LANGUAGE SPOKEN IN HOME: _____**

PARENTAL CUSTODY: Y_____ N_____

PARENT/GUARDIANSHIP/CUSTODIAN: _____
(Circle One)

ADDRESS: (If different from child)
Street: _____ City: _____ State: _____ Zip Code: _____ County: _____

TELEPHONE #'S: H ( ) _____ W ( ) _____ CELL #: _____

INS. CO. & #:_____ **MEDICAID #:_____** **SOC. SECURITY # _____ -_____ - _____**

SCHOOL DISTRICT: _____ **SCHOOL: _____** **GRADE: _____**

CPS INVOLVEMENT: Y_____ N_____ CPS WORKER: _____ PHONE: _____

LEGAL INVOLVEMENT: Y_____ N_____

CHARGES: Y_____ N_____ SPECIFY CHARGE: _____

PINS: Y_____ N_____

LAW GUARDIAN NAME:_____ **PHONE #:_____**

PROBATION NAME:_____ **PHONE#:_____**

SIGNIFICANT CONTACTS: 1) NAME _____ PHONE: _____ RELATIONSHIP: _____

REASON FOR REFERRAL:

_____

_____

HISTORY OF ABUSE – SEXUAL: Y_____ N _____ **PHYSICAL: Y _____ N _____**

CURRENT BEHAVIORS:

___	**Sexualized**	___	**Aggressive**	___	**School Avoidance**
___	**Suicidal**	___	**Abscond**	___	**Medication Noncompliance**
___	**Self-Harm**	___	**Fire Setting**	___	**Social Avoidance**
___	**Other: _____**				

Please attach any copies of safety plans developed with child and family.

REFERRED BY: (print name) _____ AGENCY:_____ TEL. #: _____

Signature: _____ **FAX #: _____**

****Please ensure Western New York Children's Psychiatric Center is provided with accurate and complete information about present and past illness, medications, hospitalizations, developmental stages and other matters related to the individual's health and development.****

AUTHORIZATION FOR RELEASE OF INFORMATION	Patient's Name (Last, First, M.I.) "C" No. ..... Sex .....Date of Birth..... Facility Name ...WNYCPC.....Unit/Ward No. .....3.....

This authorization must be completed by the patient or his/her personal representative to use/disclose protected health information, in accordance with State and federal laws and regulations. Information may be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. A separate authorization is required to use or disclose confidential HIV related information.

PART 1: Authorization to Release Information

Description of Information to be Used/Disclosed:

Purpose or Need for Information:

1. This information is being requested:
   ❑ by the individual or his/her personal representative for release to a person or entity with a demonstrable need for the information; or
   ☒Other (please describe) _____
2. The purpose of the disclosure is (please describe): Referral, Treatment and discharge planning

From/To: Name, Address, & Title of Person/ Organization/Facility/Program Disclosing / Obtaining Information	**To/From:** Name, Address, & Title of Person/Organization/Facility/ Program to Which this Disclosure is to be Made / Obtained From***NOTE:*** *If the same information is to be disclosed to multiple parties for the same purpose, for the same period of time, this authorization will apply to all parties listed here.*
Western New York Children's Psychiatric Center Mobile Integration Team (MIT) 575 Alberta Drive, Suite 200 Amherst, New York 14226 (716) 832-0720 Fax #: (716)832-5867	

A. I hereby permit the use or disclosure of the above information to the Person/Organization/Facility/Program(s) identified above. I understand that:

1. Only the information described in this form may be used and/or disclosed as a result of this authorization.
2. This information is confidential and is protected under federal privacy regulations (HIPAA) and the NYS Mental Hygiene Law and cannot legally be disclosed without my permission.
3. If this information is disclosed to someone who is not required to comply with HIPAA, then it could be redisclosed and would no longer be protected by HIPAA. However, this information will still be protected under the NYS Mental Hygiene law, which prohibits this information from being redisclosed by anyone who receives it unless the redisclosure is permitted by the NYS law (Mental Hygiene Law §33.13).
4. I have the right to revoke (take back) this authorization at any time. My revocation must be in writing on the form provided to me by *(insert name of facility/program)* ____WNYCPC_____ . I am aware that my revocation will not be effective if the persons I have authorized to use and/or disclose my protected health information have already taken action because of my earlier authorization.
5. I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the New York State Office of Mental Health, nor will it affect my eligibility for benefits.
6. I have a right to inspect and copy my own protected health information to be used and/or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 CFR §164.524 and NYS Mental Hygiene Law §33.16.

B-1. One-Time Use/Disclosure: I hereby permit the one-time use or disclosure of the information described above to the person/ organization/facility/program identified above.
My authorization will expire:

❑ When acted upon; ❑ 90 Days from this Date; ❑ Other_____

Continue on Next Page ➔

AUTHORIZATION FOR RELEASE OF INFORMATION

State of New York
OFFICE OF MENTAL HEALTH

Facility/Agency Name	Patient's Name (Last, First, M.I.)	"C"/Id. No.
WYNCPC		

B-2. Periodic Use/Disclosure: I hereby authorize the periodic use/disclosure of the information described above to the person/ organization/facility/program identified above as often as necessary to fulfill the purpose identified above.

My authorization will expire:

❑ When I am no longer receiving services from *(insert name of facility/program)* _____ ;

❑ One year from this date;

❑ Other _____

C. Patient Signature: I certify that I authorize the use of my health information as set forth in this document.

_____ _____ _____ _____

Signature of Patient or Personal Representative Date Time

_____

Patient's Name (Printed)

_____

Personal Representative's Name (Printed)

_____

Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Authorization)*

D. Witness Statement/Signature: I have witnessed the execution of this authorization and state that a copy of the signed authorization was provided to the patient and/or the patient's personal representative.

WITNESSED BY: _____
Staff person's name and title

Authorization Provided To: _____

Date: _____ Time: _____

To be Completed by Facility:

_____
Signature of Staff Person Using/Disclosing Information

_____
Title

_____ _____
Date Released Time

PART 2: Revocation of Authorization to Release Information

I hereby revoke my authorization to use/disclose information indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

I hereby refuse to authorize the use/disclosure indicated in Part I, to the Person/Organization/Facility/Program whose name and address is:

_____
_____
_____

_____ _____ _____
Signature of Patient or Personal Representative Date Time

_____
Patient's Name (Printed)

_____
Personal Representative's Name (Printed)

_____
Description of Personal Representative's Authority to Act for the Patient *(required if Personal Representative signs Revocation of Authorization)*