TIME Family Services, LLC 434.989.3579 540.223.3836 Fax – 888.709.1905 www.TIME4Family.net	**Client Name:** **Staff Name:** **Staff Phone:**
Admit Date: **Medicaid #:**	**SS#:** **DOB:**

Referral Form for Intensive Mental Health Services for Children

____ Intensive In-Home Child/Family Counseling __ Intensive In-Home Child Mentoring
__ Group Therapy

Client Information

Client Name: _____**Application Date**: _____
Last First MI

DOB: _____ Age:_____ Sex : __Male __Female SSN: _____

Ethnicity (optional): _____ Primary Language (optional): _____

Custody / Living Arrangements:
In legal custody of: _____
Address:_____
City: _____ State: _____ Zip:_____
Home phone: _____
Work phone: _____

Custody status: _____

Medical/Medicaid Insurance No.:		CSA	Adoption/Foster Care Subsity

Referral Information

Person making the referral (name & title_____
Representing which agency / committee_____
Address:_____
City: _____ State:_____ Zip:_____
Phone: _____ Fax:_____ Email: _____
Relationship to client:_____

Reason for Referral

Signature_____

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Admit Date: **Medicaid #:**	**SS#:** **DOB:**

Client Name:_____DOB:_____

I _____ hereby authorize
TIME Family Services, LLC, 33011 Indiantown Road, Locust Grove VA 22508

☐To Release Verbal / Written Information to: ☐To Obtain Verbal / Written Information from:

AGENCY NAME:_____
ADDRESS:_____
_____

The type of information to be disclosed is:

☐ Admission / Discharge Summary
☐ Psychosocial Evaluations
☐ Psychological Evaluations
☐ Psychiatric Evaluations
☐ Psychosexual Evaluations
☐ Progress Summaries
☐ Medication History
☐ MRI / Neurology Evaluations
☐ Court/Probation
☐ Other: ___

The purpose of this information disclosure is to assist in completion of Child Mental Health evaluation(s), treatment recommendations, and /or placement.

This authorization is valid until: _____Six months from the date of signature.
_____The following event or date, not to exceed one (1) year.

This consent may be revoked at any time, except to the extent that action has been taken in reliance on it. The person completing this form has a right to receive a copy. This form is invalid unless all sections are completed. Do not sign this form unless a specific request has been made and the request is in your child's best interest.

_____ _____
Client Signature (If applicable) Date Print Name

_____ _____
Parent, Guardian, Custodian Signature (Circle one) Date Print Name

This information has been disclosed from records whose confidentiality is protected by federal and state law. Any further disclosure is prohibited without the specific written consent of the person to whom it pertains, or as otherwise permitted by federal or state regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.