CLIENT #:_____

Marriage & Family Solutions, LLC

608 203 6267 Fax: 608 203 6696 7818 Big Sky Dr #101 Madison, WI 53719

Physician Referral

Date: _____

SECTION 1: PATIENT INFORMATION

Client Name: _____ DOB: _____

Client's Medical Assistance Number: _____

Diagnosis: _____

SECTION 2: PARTIES INVOLVED IN DISCLOSURE OF RECORDS

I _____, **HEREBY AUTHORIZE AND REQUEST:**
(Name of Patient or Patient's Legally Authorized Representative)

Marriage & Family Solutions, LLC
7818 Big Sky Drive, Suite 101
Madison, WI 53719—2840
P: 608-203-6267 **F:** 608-203-6696

TO RELEASE TO AND RECEIVE FROM:

Organization/Individual: _____

Address: _____

Phone: _____ **Fax:** _____

SECTION 3: INFORMATION TO BE DISCLOSED

Communication regarding client's care and well-being (intake-discharge)

SECTION 4: PURPOSE FOR DISCLOSURE

Coordination of Care

SECTION 5: UNDERSTANDING MY RIGHTS

- I understand signing this authorization is voluntary and my refusal to sign will not affect my eligibility to obtain health care benefits (treatment, payment or enrollment).
- I understand that a photocopy of this authorization shall be considered valid as the original.
- I am aware I have the right to inspect or receive a copy of the health information to be used or disclosed and this authorization.
- I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected by applicable deferral and state privacy laws.
- ***I may revoke this authorization through written notice*** to Marriage & Family Solutions, LLC at any time *(except for information already released as a result of this authorization).*

SECTION 6: SIGNATURE

Signature of Patient _____ **Date:** _____

If signed by legal representative please indicate Relationship: _____

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian

Patient is: ☐ Minor ☐ Incompetent/Incapacitated ☐ Deceased

Please check the appropriate recommendation:

I prescribe_____individual, _____family, and/or_____group psychotherapy for the above named client for a period of one year with any psychotherapist at Marriage & Family Solutions, LLC.

Physician's Signature: _____

Date: _____

Physician's National Provider Identification Number: _____