



665 W. Fourth Street  
Winston-Salem, NC 27101  
336.725.8389 phone  
336.800.8739 fax  
InsightNC.org  
connect@insightnc.org

### Referral Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ SSN #: \_\_\_\_\_

Pronouns: He/Him She/Her They/Them Gender: Male Female

Address: \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Referral Contact Information: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Has the consumer been seen at Insight Human Services before? Yes No

Insurance: Medicaid, NC Health Choice or Medicaid PHP? Yes No Uninsured? Yes No

Medicaid/NC Health Choice #: \_\_\_\_\_

Signed ROI Attached: Yes No

Collateral documentation included with Referral Form: Yes No

Additional Information:

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INSIGHT STAFF USE:

Referral ID #: \_\_\_\_\_

LME/MCO #: \_\_\_\_\_

Date referral received: \_\_\_\_\_

Assessment Date/Time: \_\_\_\_\_

Referral information entered/uploaded to myEvolv: \_\_\_\_\_

(staff initial)

Clinical Staff informed if no ROI/collateral documents are received: \_\_\_\_\_

(staff initial)

Name:  
Date:  
Insight ID #:  
MCO #:  
Medicaid/NCHC #:

DOB:



**AUTHORIZATION FOR DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION**

I hereby request and authorize **INSIGHT HUMAN SERVICES, 665 W. 4th Street, Winston-Salem, NC 27101 336-725-8389** to disclose to, receive from, and communicate with: \_\_\_\_\_

(Individual/Program/Entity and Address to whom information is to be disclosed)

the following specified amount and kind of protected health information:(please initial each that applies/mark NA if not requested)

	Assessment:Current episode of care		Psychiatric Evaluation:Current episode of care
	Treatment Plan & Diagnosis: Current episode of care		Acquired Immunodeficiency Syndrome HIV: Current episode of care
	Discharge Summary: Current episode of care		Medical History: Current episode of care
n/a	Progress notes: n/a		Medications: Current episode of care
	Financial Information: Current episode of care		Education Information: Current episode of care
	Substance Abuse Information: Current episode of care		Urine Drug Screen Results: Current episode of care
	Psychological Evaluation: Current episode of care		Other:

the purpose of disclosure is: \_\_\_\_\_

(Specific purpose for the information)

I understand that, upon request, I must be provided with a list of entities to which my information has been disclosed when I consent to information be disclosed to an entity using a general description. I understand that my records are protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42CFRPart2), HIPAA (45CFR Parts 160 and 164), and state lawG.S122C, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any even this consent expires automatically as follows:

The date this consent expires(Date/Event/Condition, not to exceed one year): \_\_\_\_\_

I certify that this authorization is made freely, voluntarily, and without coercion. I may refuse to sign this authorization form and Insight Human Services will not condition my treatment on receiving my signature on this Authorization.

\_\_\_\_\_  
Client or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian if client under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

**REVOCAION OF AUTHORIZATION/CONSENT**

I withdraw the authorization to disclose personal health information of \_\_\_\_\_  
(Verbal Request by: \_\_\_\_\_) effective on: \_\_\_\_\_

\_\_\_\_\_  
Client or Personal Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian if client under 18

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

Privacy Notification: This message and accompanying documents are covered by the Electronic Communications Privacy Act, 18 U.S.C. §§ 2510-2521, and contain information intended for the specified individual(s) only. This information is confidential. If you are not the intended recipient or an agent responsible for delivering it to the intended recipient, you are hereby notified that you have received this document in error and that any review, dissemination, copying, or the taking of any action based on the contents of this information is strictly prohibited. If you have received this communication in error, please notify us immediately by e-mail, and delete the original message.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.