For Staff Use Only:
Completed By_____
Today's Date_____

HealthNet
Your Health. Our Passion.

Referral to Behavioral Health Non-Psychiatric Services

Date_____ Medical Identification Number_____

This patient is currently being seen at our practice and is in need of a Behavioral Health Assessment from your agency.

Patient Information:
Last Name_____ First Name_____ MI_____
Last four digits of Social Security #_____ DOB_____
Phone_____
Gender_____ Preferred Pronoun(s)_____
Legal Guardian_____
Payer Source: _____Medicaid _____Medicare _____Private _____Self Pay

Referring Provider Information:
Primary Care Provider's Name_____
Practice Name_____
Address_____
Phone_____ Fax_____ Email_____
Referral NPI # (if applicable)_____
Referral Request:

Specific concerns/requests/recommendations:

Appointment Information:
Preferred HN Clinic (Please circle): People's Southwest West Southeast Barrington Care Center Martindale-Brightwood Northeast

The following patient information is attached:
____ Medical Diagnosis
____ Most Recent History and Physical
____ Current Medication List
____ Pain Agreement (if applicable)
____ Release of information Signed (reverse side)
____ I acknowledge that I have had a conversation about this referral to Behavioral Health (required)

Please fax this form and the Obtain Medical Records Form to: 317-275-3633

Signature_____
Physician, Physician Assistant/Nurse Practitioner

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Authorization to Obtain Medical Information

If you need your previous doctor, hospital or clinic to send your medical records to HealthNet, please fill out this form.

I give HealthNet consent to obtain the medical records of:

Last name _____ First name _____ MI _____

Last 4 digits of Social Security # __ __ __ __ Date of Birth _____ Phone _____
Address _____

I give HealthNet consent to obtain these medical records from:

Provider Name _____ Phone _____ Fax _____
Address _____ City _____ State _____ Zip _____

With the following information from: this date _____ / _____ / _____ **to** _____ / _____ / _____.
☐ Provider notes ☐ Billing records ☐ Labs/X-Ray ☐ Ultrasound ☐ Immunizations (Shots)
☐ Other tests/records _____ ☐ Consultations ☐ Entire medical record

Special Consent Section: *(Per IC-16-39-2. This special permission is valid for 180 days.)*
☐ Behavioral Health/Counseling records ☐ Communicable disease testing (like STIs)
☐ HIV results ☐ Genetic records ☐ Alcohol, drug, or substance abuse records

Method requested *(check one):* ☐ Paper ☐ CD/Electronic format ☐ Verbal
☐ E-Delivery *(secure link)* Email: _____

I give my consent for HealthNet to release my medical records as described above and I know:

1. If my record contains any highly private information like HIV tests or counseling records, I must check the correct box(es) above for HealthNet to release these sections.
2. To stop the release of this information, I must write a letter to the address below. Canceling the release will not apply to records that have already been sent.
3. This authorization will expire in 60 days unless I state a different date here: _____
4. The person/organization that receives my records may not have to follow federal privacy laws like HealthNet. Once HealthNet releases my records, HealthNet no longer has control over what that person/organization does with my records.
5. HealthNet will treat me even if I do not sign this form.
6. I must completely fill out this form for HealthNet to release my records.
7. If I request an electronic format, I can receive my medical records on a CD or E-Delivery.

Printed name of person completing form _____

_____ _____ _____
Signature of Patient/Legal Representative Date Relationship to Patient

Please fax this form and the Referral to BH Form to: 317-275-3633

Staff Use Only: Received by: ☐ Email ☐ Fax ☐ Mail ☐ In Person (name of staff who witnessed): _____