PROVIDER REFERRAL FORM

Mn Prevention & Recovery Alliance – Certified Peer Recovery Support Services

****Please email this form and attached ROIs (and CD Assessment, if applicable) to prss@mnpra.org****

Referral Date:_____

Client Name _____ DOB_____ Phone_____

Email _____ SSN _____

Address _____ City, State, Zip _____ County_____

Referring Organization Name _____ Referral Contact Name_____

Referral Contact Title _____ Phone _____ Email_____

Client Drug of Choice and Use History:

_____

_____

Does the client currently have justice-involvement?

- ☐ No
- ☐ Yes, explain:_____

_____

Does the client have noteworthy current/pending criminal charges/offenses?

- ☐ No
- ☐ Yes, explain: _____

_____

Are there any safety concerns for a CPRS visiting the client in-home?

- ☐ No
- ☐ Yes, explain: _____

_____

Has the client had a chemical assessment within the last 6 months?

- ☐ No
- ☐ Yes – Where? _____

*if so, please fill out ROI on next page

Would the client like to add an emergency contact?

- ☐ No Yes
- ☐ Name _____

Relationship _____

Phone _____

MnPRA admission info
(leave blank for MnPRA to fill out)

Admitted?

- ☐ Yes
- ☐ No, reason: _____

_____

*appropriate referrals will be made for any client unable to participate in MnPRA services

CPRS Provider Name _____

Date Assigned _____

CPRS phone _____

CPRS email _____

MN PREVENTION & RECOVERY ALLIANCE

EDUCATION • ADVOCACY • SUPPORT

MnPRA AUTHORIZATION TO RELEASE & DISCLOSE INFORMATION

CLIENT INFORMATION	Name_____ DOB ____/____/____ Address _____ Phone _____ City, State, Zip _____
DISCLOSING PARTY	INSURANCE Provider: _____ Address: _____ Phone: _____
RECEIVING PARTY	Mn Prevention & Recovery Alliance 740 E 24th St, Minneapolis MN 55404 ATTN: Admissions Department Email: prss@mnpra.org Phone: (612) 238-6393
INFORMATION TO BE RELEASED	I authorize the Disclosing and Receiving party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if applicable) ☐ Chemical dependency/substance use Legal ☐ Mental health/medical Financial ☐ Other (Specify): _____
RELEASE INSTRUCTIONS	Information should be released via email to prss@mnpra.org
PURPOSE OF RELEASE	Purpose of this release is to coordinate financial/insurance needed for recovery services and continued care.

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here _____ unless earlier revoked; (ii) my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; (iii) I can revoke this Authorization, in writing at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; (iv) I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnPRA address listed above; (v) once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; (vi) I can refuse to sign this Authorization and still be assured treatment; (vii) I may inspect or copy the information to be used or disclosed, as provided in the 45 CFR 164.524; (viii) a photocopy/fax of this Authorization will be treated in the same manner as the original; and (ix) MnPRA records may include records that it received from other organizations. If these records have been used by MnPRA and filed in the record MnPRA maintains about me, these records may be released with my MnPRA records.
By signing below I acknowledge that I have read and understand this form, and authorize release of the information described above.

Client Signature _____ Date _____

MnPRA AUTHORIZATION TO RELEASE & DISCLOSE INFORMATION

CLIENT INFORMATION	Name_____ DOB __/__/__ Address _____ Phone _____ City, State, Zip _____
DISCLOSING PARTY	CHEMICAL HEALTH ASSESSMENT Provider: _____ Address: _____ _____ Phone: _____
RECEIVING PARTY	Mn Prevention & Recovery Alliance 740 E 24th St, Minneapolis MN 55404 ATTN: Admissions Department Email: prss@mnpra.org Phone: (612) 238-6393
INFORMATION TO BE RELEASED	I authorize the Disclosing and Receiving party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if applicable) ☐ Chemical dependency/substance use ☐ Legal ☐ Mental health/medical ☐ Financial ☐ Other (Specify): _____
RELEASE INSTRUCTIONS	Information should be released via email to prss@mnpra.org
PURPOSE OF RELEASE	Purpose of this release is to coordinate treatment records needed for recovery services and continued care.

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here _____ unless earlier revoked; (ii) my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; (iii) I can revoke this Authorization, in writing at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; (iv) I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnPRA address listed above; (v) once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; (vi) I can refuse to sign this Authorization and still be assured treatment; (vii) I may inspect or copy the information to be used or disclosed, as provided in the 45 CFR 164.524; (viii) a photocopy/fax of this Authorization will be treated in the same manner as the original; and (ix) MnPRA records may include records that it received from other organizations. If these records have been used by MnPRA and filed in the record MnPRA maintains about me, these records may be released with my MnPRA records.
By signing below I acknowledge that I have read and understand this form, and authorize release of the information described above.

Client Signature _____ Date _____

MnPRA AUTHORIZATION TO RELEASE & DISCLOSE INFORMATION

CLIENT INFORMATION	Name_____ DOB __/__/__ Address _____ Phone _____ City, State, Zip _____
DISCLOSING PARTY	EMERGENCY CONTACT Name: _____ Relationship: __ _____ Address: _____ _____ Phone: _____
RECEIVING PARTY	Mn Prevention & Recovery Alliance 740 E 24th St, Minneapolis MN 55404 Admissions Department ATTN: Email: prss@mnpra.org Phone: (612) 238-6393
INFORMATION TO BE RELEASED	I authorize the Disclosing and Receiving party to exchange information necessary for my ongoing treatment, coordination of care and/or for payment purposes. (Check if applicable) ☐ Chemical dependency/substance use ☐ Legal ☐ Mental health/medical ☐ Financial ☐ Other (Specify): _____
RELEASE INSTRUCTIONS	Information should be released via email to prss@mnpra.org
PURPOSE OF RELEASE	Purpose of this release is to coordinate communication with above party in case of an emergency or life- threatening event.

I agree that: (i) this Authorization is effective for one year from the date I sign below (or such later expiration date as provided here _____ unless earlier revoked; (ii) my information may include information relating to sexually transmitted diseases, sickle cell anemia, AIDS, HIV, behavioral or mental health services and treatment for alcohol and drug abuse; (iii) I can revoke this Authorization, in writing at any time, but my revocation will not apply to any information to the extent that the program or person which is to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid consent to disclose information to a third party payer; (iv) I can send a request for revocation or questions about disclosures to the Medical Record Department at the MnPRA address listed above; (v) once my information is disclosed it may be re-disclosed and not be protected by federal privacy rules, and the facility cannot prevent the re-disclosure; (vi) I can refuse to sign this Authorization and still be assured treatment; (vii) I may inspect or copy the information to be used or disclosed, as provided in the 45 CFR 164.524; (viii) a photocopy/fax of this Authorization will be treated in the same manner as the original; and (ix) MnPRA records may include records that it received from other organizations. If these records have been used by MnPRA and filed in the record MnPRA maintains about me, these records may be released with my MnPRA records.
By signing below I acknowledge that I have read and understand this form, and authorize release of the information described above.

Client Signature _____ Date _____