Referral Form

Mn Prevention & Recovery Alliance – Certified Peer Recovery Support Services

Please fill out this form and attached ROIs in their entirety and email to prss@mnpra.org

Participant first & last name _____ Pronouns _____ Date of Birth_____
SSN _____ Email _____ Phone _____
Address _____ City _____ State ____ Zip _____ County _____

Referring organization _____ Referral contact name _____
Referral contact title _____ Phone _____ Email _____

Participant DOC
- ☐ Alcohol
- ☐ THC
- ☐ Opiates
- ☐ Amphetamines/stimulants
- ☐ Other

Use history
- ☐ < 1 year
- ☐ Between 1-5 years
- ☐ > 5 years
- ☐ > 10 years

Does the participant currently have justice-involvement?
- ○ No
- ○ Yes: _____ _____

Does the participant have any noteworthy current/pending criminal charges/offenses?
- ○ No
- ○ Yes: _____ _____

Are there any safety considerations a CPRS should be aware of prior to visiting participant in-home?
- ○ No
- ○ Yes: _____ _____

Has the participant completed a chemical assessment within the past year?
- ○ No
- ○ Yes: *where?* _____ _____

What type of support is the participant most interested in receiving through peer recovery support services (PRSS)?
- ☐ Education (housing, employment, life skills)
- ☐ Advocacy (CPS, probation, housing, employment, school)
- ☐ Mentorship (self-disclosure, provide support)
- ☐ Attending recovery and other support groups with the participant
- ☐ Accompanying participant to appointments that support recovery
- ☐ Providing transportation to appointments that support recovery (medical, treatment, court, job interviews, etc.)
- ☐ Assistance accessing community resources

What else should we know? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Authorization to Release & Disclose Participant Information

If **any section is incomplete this form may be invalid and the request cannot be processed.**

Participant Information

First name _____ Last name _____ DOB____/_____/_____

SSN _____-____-_____ Email _____ Phone (_____)_____-_____

Address_____ City _____ State _____ Zip_____

Disclosing Party Mn Prevention & Recovery Alliance | 740 E 24th St Minneapolis MN 55404 | Phone: (612) 238-6393 Fax: (651) 204-9383 | Email: prss@mnpra.org

Receiving Party

- ☐ Insurance: company name_____

Address_____ City _____ State _____ Zip _____

Email _____

Phone (_____)_____-_____ Fax (_____)_____-_____

Information to be Released

☐ Any and all records (including those specified on the right)

Only records checked below:

☐ Discharge summary
☐ Progress/Clinic notes
☐ Mental health records
☐ Chemical health assessment
☐ Financial records

Optional limits: Disclose records only related to the following:

☐ Date(s) of Service: _____
☐ Injury or illness _____

Release Instructions

Release method format requested: ☐ Paper ☐ Fax ☐ Verbal ☐ Email ☐ Other _____

Purpose of Release

☐ Treatment/Continued Care
☐ Personal*
☐ Progress Notes
☐ Transfer of Care
☐ Financial/Insurance
☐ Legal*
☐ Other _____

***Fees may be charged in accordance with MN Statute 144.292 and Federal Rule CFR 164.524*

I agree that: (i) this Authorization is effective for one year from the date I sign below unless earlier revoked; (ii) my information may include information relating to sexually transmitted disesases, 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 refused to sign this Authorization and still be assured services; (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. (x) By initialing I understand that I specifically authorize the disclosure/exchange of information related to my chemical dependency and/or substance abuse. _____

By signing below I acknowledge that I have read and understand this form, and authorize release of the information described above.

Participant signature _____ Date_____/_____/_____

Authorization to Release & Disclose Participant Information

If **any section is incomplete this form may be invalid and the request cannot be processed.**

Participant Information

First name _____ Last name _____ DOB____/_____/_____

SSN _____-____-_____ Email _____ Phone (_____)_____-_____

Address_____ City _____ State _____ Zip_____

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Receiving Party

- ☐ Chemical/Mental health treatment provider _____

Address_____ City _____ State _____ Zip _____

Email _____

Phone (_____)_____-_____ Fax (_____)_____-_____

Information to be Released

☐ Any and all records (including those specified on the right)

Only records checked below:

☐ Discharge summary
☐ Progress/Clinic notes
☐ Mental health records
☐ Chemical health assessment
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