# PROMOTING ACCESS TO HOPE
# PATH TEAM

## REFERRAL FORM

****Please include attached ROIs for care coordination****

| | |
|---|---|
| Program referral:<br>Please check one | ☐PATH Team : pathteam@multco.us<br>☐Ryan White (individuals living with HIV ): rwabc@multco.us<br>☐Problem Gambling: reginald.stroughter@multco.us |

| | | | |
|---|---|---|---|
| Client Name: | | Date of Referral: | |
| Gender Identity: | | Pronouns: | |
| Race: | | Ethnicity: | |
| DOB: | | Language preference | ☐English ☐ Spanish ☐ Other:_____ |
| **Check all that apply:** | Veteran ☐ Pregnant ☐ IV use ☐ Child Welfare Involvement ☐ BIPOC ☐HIV+ ☐ LGBTQ+ ☐Other ☐ | | |
| Insurance Provider: | OHP ID: CCO: | County of coverage (must be Multnomah unless Ryan White funded) | |
| Phone number: | | Text ok? ☐ Email ok? ☐<br>email: | OK to leave a message? ☐ |
| **Reason For Referral:** | | | |
| Current/Recent Substance use: | | | |
| Current Legal Involvement: | | | |
| Housing status: | | | |
| Hangout area? (eg. NE, SE, North, etc.) | ☐North ☐Northeast ☐Inter Northeast ☐Gresham ☐Mid County, ☐East of 82nd ☐Downtown<br>☐other _____<br>Write specific location (eg. under burnside bridge, dawson park, Union station, street corners etc.) | | |

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|---|---|
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| Any known medical/mobility needs: | |
| Mental Health Diagnosis: | |
| Recent ED Visits/Hospital admissions | |
| SI History | |
| **Problem Gambling** | Does the client have a history of Gambling? ☐Yes ☐ No |

**PROVIDER INFORMATION OR REFERRAL SOURCE**

☐Hospital ☐Unity ☐PCP ☐MITT ☐ TC911 ☐ Behavioral Health Provider ☐ DCJ
Other ☐_____

| | |
|---|---|
| Agency Name: | |
| Contact Name: | |
| Phone: | |
| Email: | |
| Other Providers Involved: | |

**ADDITIONAL INFORMATION**

**MULTNOMAH COUNTY**
Health Department
Behavioral Health Division (BHD)
209 SW 4th Avenue, Suite 520, Portland, OR 97204
Phone: 503-988-8238 Fax: 503-988-4015

# AUTHORIZATION FOR RELEASE OF INFORMATION

****Please have client sign this ROI for care coordination purposes****

Last Name: _____ First Name: _____ Middle: _____ DOB: _____

I authorize the Behavioral Health Division to exchange and disclose the following information with the individual/organization named below: **Mark** all appropriate box(es) and give complete name and address:

☑ To exchange information with: Individual/Organization: Past, Present and Future Providers AND
☑ To disclose health/medication records to: Joint Office of Homeless Services/Homeless Info Mngt System (HMIS)
☐ To receive health/medication records from: Contact Person/Attention: _____
☐ To verbally exchange information with: Street Address: _____
City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

**Purpose**: I authorize the exchange or disclosure of the health information for the following reasons:
☑ Care Coordination ☑ Treatment ☑ Payment ☑ Other: Case Management and Housing Assistance

Information to be exchanged or disclosed:
☑ All of my health information
☐ All of my treatment information
☑ Specific documents/information: Substance use and Mental Health records including diagnosis, referral, treatment, and discharge information; demographic information

By **marking** the spaces below, I specifically authorize the disclosure of the following health information, if such information exists:
☑ Drug/Alcohol diagnosis, treatment or referral information ☐ Genetic testing information ☑ HIV/AIDS related records
☑ Mental Health information

This authorization will expire in one (1) year, or upon (insert date or event): _____

**CLIENT ACKNOWLEDGEMENT AND AGREEMENT**
I understand that a recipient may re-disclose information received unless prohibited under federal/state law or my specific consent is required. I am aware that if the recipient re-discloses my information, privacy protections provided by law may be lost. I understand that substance use disorder treatment records may be protected under the federal regulations governing Confidentiality of Substance Use Disorder Patient Records (42 CFR Part 2) and cannot be re-disclosed without my written consent unless otherwise permitted or required by law. If I have named an intermediary, the intermediary may re-disclose my substance use disorder information to verified treating providers and I may request a list of re-disclosures directly from the intermediary.

I may revoke this authorization in writing at any time to any BHD staff. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand signing this authorization is not a condition to receive treatment, payment, or eligibility.

Signature of Individual/Legal Guardian _____ Printed Name _____ Date _____

**REVOCATION: I no longer authorize the exchange or disclosure of my health information.**

Signature of Individual/Legal Guardian _____ Printed Name _____ Date/Time _____

**STAFF USE ONLY**
☐ Individual/legal guardian revoked verbally (phone or other): _____

MHASD Staff Member Signature/Credential _____ Printed Name _____ Date/Time _____