Erin Vandermore, MA. , LPC
erinvandermore@medofficemail.com
erinvandermore.org

Email Referrals To: *erinvandermore@medofficemail.com*

Referred by:_____ Referral Phone #:_____

Student Name:_____ DOB:_____

School:_____ Grade: _____ Teacher: _____

Parent/Guardian: _____ Home #: _____ Cell #: _____

Insurance (check one): __BC/BS __Other Private Ins.: _____ ___

Reason for Referral: _____

_____

Classroom Interventions / Response: _____

_____

Yes _____ No _____ Parent / Guardian is aware of the referral being made to Mrs. Erin Vandermore M.A., LPC

_____ _____
Signature of Client or Guardian Date

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By signing below, I give my permission for Mrs. Erin Vandermore, M.A., LPC to release and/or receive my child's confidential information to/from

_____ . The Information to be released, shared, and exchanged will be concerning continuation of care.
Referral Source

Initiation of Services and the purpose of this release is for Continuation of Care.

- I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Information Portability and Accountability Act of 1996 ("HIPAA"), 45 CFR, part 160 & 164 the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.
- I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.
- I understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____/_____/_____
Signature of Client/Guardian Relationship Date Signed