Richard Boland, LCSW
Medical Arts Building Suite 1147
1169 Eastern Parkway
Louisville, KY 40217

PATIENT INFORMATION FORM

NAME______________________________ DATE____________

ADDRESS____________________________________

____

SOCIAL SECURITY NUMBER________________________

HOME PHONE________________CELL PHONE________________

WORK PHONE________________EMAIL ADDRESS________________

(check for which phones it is ok to leave a message and if email is ok for a message)

REFERRAL SOURCE______________________________

PHYSICIAN__________________________________

DATE OF BIRTH______________________________

MARITAL STATUS________ SPOUSE/PARTNER____________________

CHILDREN__________________________________

EMPLOYER__________________________________

PARTNER'S EMPLOYER____________________________

OCCUPATION/SCHOOL____________________________

INSURANCE CO.(if using insurance)________________________

PREVIOUS TREATMENT____________________________

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Release of Information

Patient Name: ____

Date of Birth:________________SSN:__________________________

Address:____

Phone Number:____

I authorize Richard Boland, LCSW. to release [_] obtain[_] information concerning services provided to the above-named individual to [_] from [_]:

____

Name | Agency | Phone Number

____

Address

Specific information needed includes:

[_] discharge/termination summary
[_] dates of treatment
[_] medical and physical history
[_] diagnosis
[_] progress notes
[_] psychological evaluation
[_] medication history
[_] other:________________

Purpose of disclosure:
[_] coordination of treatment
[_] insurance reimbursement

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42 C.F.R., Part 2) prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted by C.F.R., part 2. The general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

I have read or been informed that all blanks are properly filled in prior to my signature, and I understand that this form is not required as a condition for treatment. This authorization expires in six months or ________. This release is subject to revocation at any time except to the extent that the program which is to make the disclosure has already taken action in reliance on it.

______________________________ ____________________

Signature of Client, Parent, or Guardian | Date

______________________________ ____________________

Witness | Date