Therapy Referral Form

Student Name: _____ D.O.B._____

School: _____ Grade: _____

Parent Name: _____ Parent Phone: _____

Referral Source: _____

Reason for referral: _____

_____

Follow-Up Plan:
(Please check all that apply):

☐ School Release of information signed by student/parent for release to E3 program and copy attached

☐ Parent/Guardian has been contacted and agreed to service

☐ Parent/Guardian has been given program information and is aware that the program will bill the child's insurance carrier for the therapy services provided

Fax form to: E3 Program (920) 882-5484

Hortonville Area School District

PERMISSION TO OBTAIN AND RELEASE INFORMATION WITH E3

Dear: _____ Date: _____

(parent/legal guardian) Student Name:_____

Student's Date of Birth: _____

In order for us to obtain and release information regarding your child please review and agree to the items below by providing your signature of consent. If you have any questions, contact us at: (920) 779-7934 or E3 at (920) 750-7088.

PARENT PERMISSION TO OBTAIN AND RELEASE INFORMATION

I, the undersigned, hereby request and authorize:

School/Agencies: *Hortonville Area School District*

Attention: *Linda Gorges/Kerry Franklin (School Psychologist)*

To release information to:

Agencies: *Catalpa Health* School/Program: *E3 Program @ HASD*

Address: *W6822 Greenridge Dr. Greenville, WI 54942*

Person requesting information: *E3 Program*

The information which I have indicated below:

(X) Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, and group aptitude and achievement test results)

( ) Medical and/or related health records. Type of provider:

(X) Medical history/diagnostic/therapeutic information from:_____ to:_____ including:

- (X) Mental Health
- ( ) HIV
- (X) Developmental/Learning Disability
- (X) Drug/Alcohol Abuse
- ( ) Specific information (i.e., x-ray films, photographs)
- (X) Verbal exchange of information with: *HASD Staff*
- ( ) Medical information limited to:
- (X) Psychological evaluations or social work reports
- (X) Evaluation and related reports
- (X) Appropriate agency reports
- (X) Individualized education program
- ( ) Other (specify):

Purpose of disclosure: *Program and intervention planning between agencies.*

****This permission is valid for one year from the date signed. A copy of this form is as effective as the original.**

I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent and that the written revocation must be given to the agency/organization I authorized to release information. I recognize that health records, once received by the school district, may not be protected by the HIPPA Privacy Act and may become education records protected by the Family Educational Rights and Privacy Act (FERPA) with additional protection afforded by Wisconsin statues 118.25 (2m)(a)(b) and 146.83. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

Signature of parent / relationship to student *Date*