SULCATA PSYCHIATRY
118 Vintage Park Blvd, Ste W609
Houston, Texas 77070
Phone: 281-747-8588
Fax: 281-666-8880

PATIENT REFERRAL FORM

If urgent referral required, please contact office directly by phone at 281-747-8588 to schedule.

Referring Provider Information

Provider Name: ______________________________ Specialty: ______________________________

Office Phone: ________________________________ Office Fax: _____________________________

Date of Referral: ______________________________

Patient Information

Patient Name: ________________________________ Date of Birth: ____________________________

Patient Phone: ________________________________ Email: ___________________________________

Patient Address: ______________________________ City/State/Zip: ___________________________

Diagnosis or Reason for Referral:

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Please attach diagnosis list (including medical), current medication list, and recent labs if available, along with most recent note.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please fill our appropriate information in each applicable section. Sign and Date the form. A separate authorization must be completed for each request.

PATIENT INFORMATION

Full Name: ____ Date of Birth: ______________

Previous/Maiden Name: _________________________________ Biological Sex: Male / Female

Email: ____ Phone:____________________

Address: Street: ____

City: _______________________ State: ____________ Zip: _______________

Name of title of person or organization and address to whom information is to be shared:

Obtained FROM:

Name:

Address:

Phone/Fax:

Disclosed TO:

Sulcata Psychiatry

118 Vintage Park Blvd, Suite W609

Houston, Texas 77070

Phone: 281-747-8588 / Fax: 281-666-8880

Direct messaging available at: stonijohnston@sulcatapsychiatry.kareodirect.com

Dates Valid:

This authorization is valid for TWO (2) YEARS from the date of signature below, unless otherwise specified here: ____

Records to be Released:

including written, electronic, and verbal communication

☐ Entire Chart/Record, treatment, services, supplies and medicines

☐ Lab/Imaging/Test Results

Specialized Information Release:

☐ Psychotherapy Notes

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☐ Billing/Claims/Payment Information

☐ Genetic Testing

☐ Diagnosis List

☐ Medication List and History

☐ Discharge Summary

☐ Immunizations

☐ HIV infection/communicable disease status or test results

☐ Alcohol or Substance Abuse Treatment

☐ Other:____________________

Dates of Service:

☐ All

☐ Last 12 months

☐ Other: ____________________

Patient Rights

- I may revoke this Authorization at any time in writing. The revocation will not apply to information that has already been released in response to this Authorization.
- I may refuse to sign this Authorization. My treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned upon my authorization of this disclosure.
- I have been informed and understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law.
- I understand that I have the right to request a list of recipients to who may receive or use my medical information without a written authorization. I understand that I have the right to receive a copy of this signed form and that a copy of this form (including a fax) is considered as valid as the original.

Acknowledgement and Consent

By signing below hereby authorize disclosure of information contained in the medical record of the patient identified above, which includes information related to medical, laboratory, mental health records, psychiatric diagnosis and treatment, substance abuse issues, and psychotherapy notes.

Signature: ____ Date: ______________________

Printed Name of Patient/Legal Representative: ____