PROVIDER REFERRAL REQUEST FORM

REFERRING FROM:

Referring Providers Name: _____

Providers Phone: _____ Providers Fax: _____

Providers Email: _____

Specialty: _____

Practice Name: _____

Address: _____

Please Schedule:

☐ Urgent

☐ First Available with any Physician

REFERRING:

Patients Full Legal Name: _____

If Patient is under 18 - Parents Name: _____

Date of Birth: _____ Phone Number: _____

Special Patient Considerations: _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Insurance Phone: _____

Policy Holder Name: _____ Birthdate: ____-____-_____

Policy/ID Number: _____ Group Number: _____

Employer: _____ Relationship of Patient to Insured: _____

Reason for Referral: _____

Diagnosis: _____

Patient aware of the Referral?

☐ Yes

☐ No, Explain: _____

Date: _____

2303 SE 17TH Street, #102, Ocala, FL 34471 • (Phone) 352-622-4488 (Fax) 352-565-2196

AUTHORIZATION - RELEASE OF INFO

A signed revocation may be submitted at any time, but Ocala Consulting & Prevention, LLC shall not be held liable for any information released prior to its receipt. Information disclosed under this authorization might be re disclosed by the recipient and this re-disclosure may no longer be protected by federal or state law. Your signature on this authorization is not required to receive treatment. This release form shall be valid for (check one):

☐ A single disclosure (OR)

☐ A continuing disclosure for 90 days from signature date below (OR)

☐ A continuing disclosure for 1 year from signature date below.

To Receiving Agency:
PROHIBITION OF RE-DISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read, or have had read to me, this authorization and fully understand its contents. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

☐ Client ☐ Parent/ Guardian

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Witness: _____ Date: _____

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