SAFE OPTIONS SUPPORT REFERRAL PACKAGE:

Referral Agency/Program: _____

Referring Worker's Name: _____

Contact Phone: _____ E-mail: _____

Alternative Contact: _____ Contact Info: _____

CONSENT TO RELEASE INFORMATION

I authorize _____(referring provider) to disclose the completed Safe Options Support Referral Application and all related supporting documents (Application), including confidential medical and mental health information, to Coordinated Behavioral Care (CBC), 55 Broadway, New York, NY 10006, for the purposes of CBC conducting a clinical assessment and coordinating health care and related services, including community support services and housing placement assistance, for a period of one hundred and twenty (120) days. As part of this referral process, I understand that CBC will separately obtain my authorization and consent as part of the initial assessment and intake process before providing or coordinating the provision of any additional health care services.

I understand that I may revoke my consent to disclose the completed Application at any time. My revocation must be in writing. I am aware that my revocation will not be effective if CBC has already received the Application because of my earlier authorization and consent; however, I can instruct CBC to take no further action following its receipt of the Application.

I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment nor will it affect my eligibility for benefits.

Applicant Name (please print)	Applicant Signature	Date

Witness Name (please print)	Witness Signature	Date

Applicant Name: _____ DOB: _____

Gender: ◯ Male ◯ Female ◯ Transgender ◯ Other _____

Insurance Type and #: (if known) _____ SS #: _____

Address (known location): _____ Phone #: _____

Residence Name (if applicable): _____ Primary Language: _____

Outpatient Behavioral Health and Medical Clinics / Health Home/ Outreach Team / Shelter:

Provider/Clinic Name:	Address:	Contact Info: (Telephone/Email)

Any known Behavioral Health Diagnosis: _____

Any known Substance Use Diagnoses: _____

Any known Medical Disorders: _____

Please include the following items with this referral package, if available:

☐ Psychosocial assessment & psychiatric evaluation
☐ PSYCKES summary

Email Documentation to SOSInfo@cbcare.org