Coos County Child and Youth Services Universal Referral Form
Updated 9/13/18

Date: ____________________

Please initial for requested service(s)*:
___ Advanced Health
___ Babies First/Parents As Teachers (CHW Public Health)
___ Bandon School District
___ CaCoon (CHW Public Health)
___ Children’s Program (CHW Behavioral Health)
___ Community Connections Network
___ Community Living Case Management
___ Confederated Tribes of Coos, Lower Umpqua, Siuslaw
___ Coos Bay School District
___ Dental Care Provider:
___ Early Head Start (Oregon Coast Community Action)
___ South Coast Educational Services District
___ Family to Family (OHSU)
___ Family Support and Connections (ORCCA)
___ Head Start (Oregon Coast Community Action)
___ Healthy Families Oregon (Southwestern)
___ MOMS Program (Bay Area Hospital)
___ Moms in Recovery (ADAPT)
___ North Bend School District
___ North Bend Medical Center
___ Parent Child Interaction Therapy (Behavioral Health)
___ Pathways to Positive Parenting (Southwestern)
___ Primary Care Provider:
___ Powers School District
___ South Coast Family Harbor (Relief Nursery)
___ South Coast Families First
___ Vision Provider:
___ WIC: Women Infant Children (WHC Public Health)
___ Other: ____________________
___ Other: ____________________
___ Other: ____________________
___ Other: ____________________

Parent Name ____________________ Birth Date ________ Due Date (if pregnant) ________ Youth’s Doctor ____________________

Youth’s Name ____________________ Birth Date ________ Race ________ Youth’s Medical Card # ____________________

E-mail Address ____________________ Phone ____________________ Message Phone & Name ____________________

Physical Address ____________________ Mailing Address ____________________

Referred By ____________________ Program/Agency ____________________ Phone/Extension ____________________ E-mail Address ____________________

Narrative/Pertinent Information: ____________________

Follow up: (For use by program receiving referral) ____________________

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Completion of this side is optional based on need

Authorization to Use and/or Disclose Educational and Protected Health Information

1. I authorize the following provider(s) to use and/or disclose educational and/or protected health information regarding me/my child:

_________________________________________  
(Name)  
_________________________________________  
(Date of Birth)  
_________________________________________  
(Other Names Used)  
_________________________________________  
(School or Program Name)

Name and address of health care provider authorized to:  
☐ Send/disclose protected health information  
☐ Receive/use educational information

Name and address of school/EI/ECSE program authorized to:  
☐ Send/disclose educational information  
☐ Receive/use protected health information

2. I understand that this information will be used for the following purposes (check all that apply):

☐ Determining eligibility for Special education, EIIECSE, or other services  
☐ Developing an individualized health plan  
☐ Developing an appropriate Individualized Educational program or Individualized Family Service Plan  
☐ Other (specify): __________________________

3. By marking the boxes below, I authorize the use/disclosure of the following specific medical and/or educational records:

☐ Physician’s Eligibility Statement  
☐ Health Assessment Statement  
☐ History and physical exam  
☐ Entire medical record  
☐ Prenatal information  
☐ Drug/alcohol diagnosis, treatment or referral information requested: __________________________

☐ Educational information  
☐ IFSP/IEP document  
☐ Clinic records  
☐ Communicable disease(s)  
☐ Progress notes  
☐ HIV/DIDS related records requested: __________________________

☐ Psychological evaluations  
☐ Social work reports  
☐ Other: __________________________

☐ Mental health related information requested: __________________________

☐ Genetic testing information requested: __________________________

4. By initialing the spaces below, I authorize the use/disclosure of the following information. Specific records requests must be listed below, e.g., assessment, treatment plan, and discharge plan.

Drug/alcohol diagnosis, treatment or referral information requested: __________________________

HIV/DIDS related records requested: __________________________

Mental health related information requested: __________________________

Genetic testing information requested: __________________________

5. I understand that:

a. This authorization is voluntary and I may refuse to sign it without affecting my child’s health care.

b. I have the right to request a copy of this form after I sign it as well as inspect or copy and information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR 164.524).

c. I may revoke this authorization at any time by notifying __________________________ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.

d. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses, or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

e. Federal privacy rules for education information apply only to schools and EI/ECSE programs. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

6. I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons state above is prohibited. The consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

_________________________________________  
(Signature of Parent, Legal Guardian, Student/Child)  
_________________________________________  
(Date)

(relationship)  
_________________________________________  
_________________________________________  
_________________________________________  

This authorization expires on __________________________. Not to exceed 1 year from date of signature, above.