Practice Name

Portable Medical Summary

Date Completed Date Revised

Child's Name Nickname
DOB
Parent (Caregiver) (Relationship)
Address
Phone #(home) Blocked? Y ☐ N ☐ Best Time to Reach
E-Mail
Emergency Contact Phone Relationship
Health Insurance/Plan Identification #

Diagnose(s): Primary: Secondary: Secondary:

Emergency Plan Yes ☐ Not Applicable ☐

Allergies

Allergies	Reactions:

MEDICATIONS:

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

SPECIALISTS:

PROVIDER	HOSPITAL	Phone

Vital Sign (baselines): Ht Wt Other

Problem List and recommended actions (check all that apply, please explain in space below):

Problem	**Recommended Action**
☐Behavioral	
☐Communication	
☐Feed & Swallowing	
☐Hearing/Vision	
☐Learning	
☐Orthopedic/Musculoskeletal	
☐Physical Anomalies	
☐Sensory	
☐Stamina/Fatigue	
☐Respiratory	
☐Other	
☐Other	

TO BE AVOIDED:

☐Medical Procedures:

☐Activities:
☐Foods:

PRIOR SURGERIES/PROCEDURES:

#1		Date
#2		Date
#3		Date

MOST RECENT LABS/DIAGNOSTICS (AS APPROPRIATE):

TEST	DATE OF PROCEDURE	RESULT	
LABWORK (Specify)		**Normal**	**Abnormal**
		☐	☐
		☐	☐
		☐	☐
DRUG LEVELS (Specify)			
		☐	☐
		☐	☐
		☐	☐
EEG		☐	☐
EKG		☐	☐
X-Ray		☐	☐
C-Spine		☐	☐
MRI/CT		☐	☐
Other		☐	☐
Other		☐	☐

EQUIPMENT/APPLIANCES/ASSISTIVE TECHNOLOGY:

☐Gastrostomy	☐Adaptive Seating		☐Wheelchair
☐Tracheostomy	☐Communication Device		☐Orthotics
☐Suctions	Monitors:		☐Crutches
☐Nebulizer	☐Apnea	☐O2	☐Walker
☐Other	☐Cardiac	☐Glucose	
☐Other			

SCHOOL/COMMUNITY INFORMATION:

AGENCY/SCHOOL/CHILD CARE	CONTACT INFORMATION	
	Contact Person:	Phone:
	Contact Person:	Phone:
	Contact Person:	Phone:

FAMILY INFORMATION:

★ SPECIAL CIRCUMSTANCES/COMMENT/FAMILY/YOUTH WANTS US TO KNOW★:

Parent/Caregiver Signature　　Date

Primary Care Provider Signature　　Print Name　　Contact Info　　Date

Care Coordinator Signature　　Print Name　　Contact Info　　Date

Getting to Know my Child

child's name ______________________________

parent/guardian ______________________________

email ______________________ Daytime Telephone: ______________

My Child's Strengths Are

My Child's Interests / Activities Are

My Child's Challenges Are

Hints for Working with my Child

`

The information on this page is written to help you work with and enjoy our child.
Thank you for taking the time to read this. It can make all the difference for him/her.

Massachusetts Department of Public Health
Authorization for Release of Information
Permission to Share Information

If you want the ________________________to share information about you with another person or
(Fill in name of person or organization)
organization, please make sure that you fill out all of the sections below (Sections I-VI). This will tell us what information you want us to share and who to share it with. If you leave any sections blank, with the exception of Section II (B), your permission will not be valid, and we will not be able to share your information with the person(s) or organization you listed on this form.

SECTION I

I, ____, give my permission for ________________________
(print your name) (Fill in name of person or organization)
to share the information about me that I list in Section II with the person(s) or organization that I list in Section V.

SECTION II

A. Health and Personal Information

Please describe the information you want the ________________________ to share about you.
(Fill in name of person or organization)
Please include any dates and details you want to share.

____

____

____

____

B. Permission about Specific Health Information. Only if you choose to share any of the following information, please write your initials on the line:

_____I specifically give permission, as required by M.G.L. c. 111, § 70F, to share information in my record about HIV antibody and antigen testing, and HIV/AIDS diagnosis or HIV/AIDS treatment.

____I specifically give permission, as required by M.G.L. c. 111, §70G, to share information in my record about my genetic information.

____I specifically give permission to share information in my record about alcohol or drug treatment. If this information is shared, I understand that a specific notice required by 42 CFR, Part 2 shall be included prohibiting the redisclosure of this confidential information.

SECTION III – Reason for Sharing this Information

Please describe the reason(s) for sharing this information. If you do not want to list reasons, you may simply write: “at my request,” if you are initiating the request.

____

____

____

SECTION IV – Who May Share This Information

I give permission to the person or organization listed below to share the information I listed in Section II:

____
Name

____
Organization

____
Address

____

Massachusetts Department of Public Health
Authorization for Release of Information

SECTION V – Who May Receive My Information
The person or organization listed in Section IV may share the information I listed in Section II with this person(s) or organization:

____
Name
____
Organization
____
Address
____

I understand that the person(s) or organization listed in this section may not be covered by federal or state privacy laws, and that they may be able to further share the information that is given to them.

SECTION VI – How Long This Permission Lasts
This permission to share my information is good until ____.
Indicate date or event
If I do not list a date or event, this permission will last for one year from the date it is signed.

- I understand that I can change my mind and cancel this permission at any time. To do this, I need to write a letter to ____________________, and send it or bring it to the place where I am now giving (Fill in name of person or organization) this permission (or fill in specific location*)* If the information has already been given out by, I understand that it is too late for me to change my mind and cancel the permission.

- I understand that I do not have to give permission to share my information with the person(s) or organization I listed in Section V.

- I understand that if I choose not to give this permission or if I cancel my permission, I will still be able to receive any treatment or benefits that I am entitled to, as long as this information is not needed to determine if I am eligible for services or to pay for the services that I receive.

SECTION V – Signature
Please sign and date this form, and print your name.

______________________________ ______________________________
Your Signature Date

____
Print Your Name

If this form is being filled out by someone who has the legal authority to act for you (such as the parent of a minor child, a court appointed guardian or executor, a custodial parent, or a health care agent), please:

Print the name of the person filling out this form: ______________________________

Signature of the person filling out this form: ______________________________

Describe how this person has legal authority for this individual: ______________________________

____

Combined MCE Behavioral Health Provider/Primary Care Provider Communication Form

Health Plan: Boston Medical Center HealthNet Plan Network Health Fallon Community Health Plan Neighborhood Health Plan PCC Plan HNE

The member below is currently receiving services and has consented to share the following information between his/her PCP and BH provider.

In an effort to increase communication and promote care coordination between providers, we ask that you review and/or complete the following health information.

Member name: ______________________ DOB: __________ Member ID#: __________

A signed copy of the release of information (ROI) must be attached to this form. Indicate date of expiration of ROI: ______________

Section A: *(completed by BH Provider)*

1. The patient is being treated for the following behavioral health problem(s) and/or diagnoses: (list all)

______________ ______________
______________ ______________

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

______________ ______________
______________ ______________
______________ ______________

Prescriber: ______________________

3. The patient has the following substance abuse problem(s) (if applicable):

____
____
____

4. Please describe any special concerns:

____
____
____
____

Behavioral Health Clinician: ______________________

Behavioral Health Clinician Signature: ______________________

Provider Name/Site Name: ______________________

Address: ______________________
____
____

Phone: ______________________

Fax: ______________________

Date this form completed:

Section B: *(completed by Primary Care Provider)*

1. The patient is being treated for the following medical problem(s) and/or diagnoses: (list all)

______________ ______________
______________ ______________

2. The patient is taking the following medication(s): (list all prescribed and OTC medications, with dosage and frequency as applicable)

______________ ______________
______________ ______________
______________ ______________

3. The patient has the following BH (MH/SA) problem(s) (if applicable):

____
____

4. Please describe any special concerns (i.e., include abnormal lab results):

____
____
____
____
____

Primary Care Provider: ______________________

Primary Care Provider Signature: ______________________

Provider Name/Site Name: ______________________

Address: ______________________
____
____

Phone: ______________________

Fax: ______________________

Date this form completed:

To make a referral to Care Management, please call the members' plan at:

Boston Medical Center HealthNet Plan: (866) 444-5155 • Network Health: (888) 257-1986 • Fallon Community Health Plan: (888) 421-8861

Neighborhood Health Plan: (800) 414-2820 • Primary Care Clinician Plan: (617) 790-5633 • Health New England: (617) 790-5633

(Updated 10/15/2010)

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information

Two-Way

Name: **Other Name(s):**

Address: **Phone:**

Social Security #: **Date of Birth:**

I authorize the Department of Mental Health (DMH) to receive and release information from or to the person, agency or facility named below, either verbally or in writing, as indicated in this authorization.

Name: **Attention:** **Phone:**

Street: **City/Town:** **State:**
Zip:

DMH Contact Information:

Name: **Phone:**

Address:

The person filling out this form must provide details as to date(s) of requested information. Please note that a request for release of psychotherapy notes cannot be combined with any other type of request. Specify information to be released e.g., Entire Record, Admission(s) Documentation, Discharge Summary(ies), Transfer Summary(ies), Evaluations, Assessments and Tests, Consultation(s) including names of consultant(s), Treatment Plan(s), ISP(s) & IAP(s), Physical Exam & Lab Reports, Progress Note(s):

____
____
____
____
____
____
____

Purpose for the authorization:

☐ The subject of the information or Personal Representative initiated the authorization (specific purpose not required)
or

☐ Coordinate care ☐ Facilitate billing

☐ Referral ☐ Obtain insurance, financial or other benefits

☐ Other purpose (please specify)

A copy of this authorization shall be considered as valid as the original.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF MENTAL HEALTH

Authorization for Release of Information
Two-Way (continued)

Name of person/facility/agency other than DMH to receive or release information:______________________________

I understand that I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present it to DMH at DMH address identified on page one. I understand that the revocation will not apply to information that has already been released pursuant to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire (specify a date, time period or an event)__________________________ or, if nothing is specified, it will expire when I am no longer receiving services from DMH. I understand that once the above information is disclosed to a person, facility or agency outside DMH, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to receive treatment or services from DMH and/or the other named person, facility or agency. However, lack of ability to share or obtain information may prevent DMH, and/or the other named person, facility or agency, from providing appropriate and necessary care.

X ____ ___________________________
Your signature or Personal Representative's signature Date

____
Print name of signer

THE FOLLOWING INFORMATION IS NEEDED IF SIGNED BY A PERSONAL REPRESENTATIVE

Type of authority (e.g., court appointed, custodial parent) ____

Specially Authorized Releases of Information (please initial all that apply)
____ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation 42 CFR, Part 2, I specifically authorize release of such information.

____ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by MGL c.111 §70F, an HIV/AIDS diagnosis or treatment, I specifically authorize disclosure of such information.

X ____ ________________
Your signature or Personal Representative's signature Date

INSTRUCTIONS:
1. This form must be completed in full to be considered valid.
2. Distribution of copies: original to appropriate DMH record; copy to Individual or Personal Representative; copy to person/facility/agency making request.

DMH Authorization for Release of Information-Two Way
HIPPA-F-4 (4/7/11)

<<District Name>>
HIPAA/FERPA Compliant Authorization for the Exchange of Educational And Health Information

Patient/Student Name: ____**Date of Birth**: ____________

School: _______________________________________

Phone: _________________________ **Fax:** _________________________

School Nurse: ___________________________ **Health Care Provider:** ___________________________

*The purpose of this form is to facilitate communication between a **school nurse** and the child's **health care provider**, for the purposes of optimizing the student's learning experience. The school nurse may share information provided in this medical report with appropriate members of the educational team for use in meeting the student's health and educational needs. This will be done on a "need to know" basis, in a confidential manner and may also include communication between health provider and school nurse to facilitate this process.. Likewise, the medical provider may share information with the hospital or clinical team. Only those areas listed below will be shared.*

Health information from Health Care Provider to School (May attach additional management plans and ICHP) Issue: Information to be shared:	**Educational Information from the school to the Health Care Provider** Issue Information to be shared:

Authorization

This authorization is valid for one calendar year. It will expire on ____________ I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. By agreeing to allow communication between the Health care provider and designated school health I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

____
Parent Signature Date

____
Student Signature* Date

*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Massachusetts, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

Early Childhood Developmental Interagency Referral Communication Form

The information contained in this form is privileged and confidential information. If you are neither the intended recipient nor the employee or agent responsible for delivering this information to the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the content of this telecopied information is strictly prohibited. When sending this form, always attach the patient's current consent form.	Date:

TO:				FROM:			
			(name, title)				(name, title)
	(phone)		(fax)		(phone)		(fax)
			(address)				(address)
			(program / agency)				(program / agency)

CHILD INFORMATION

Child ID Number:	Child's Name:	DOB:	Gender: ☐ M ☐ F
Parent / Legal Guardian:		Relationship:	
Primary Language: ☐ English ☐ Spanish ☐ Hmong ☐ Somali ☐ Other		Interpreter Needed:	☐ Yes ☐ No
Home Address:	Phone:	Insurance:	
Known Pertinent Medical History:			

*******REASON FOR REFERRAL** (please check all that apply)*****

☐ Developmental Screening Tool Concern	Developmental tool used:
☐ Mental Health Screening Tool Concern	Mental Health tool used:
☐ Medical/Health/Growth Concern	(list)
☐ Suspected developmental delay or concern	☐ Motor/Physical ☐ Speech/Language ☐ Cognitive ☐ Social Emotional ☐ Vision ☐ Hearing ☐ Other ☐ Behavior/Adaptive
Other/ Comments:	
Identified automatic qualification condition for early childhood services? ☐ No ☐ Yes (if yes, list)	

OTHER REFERRALS (In process = IP; Receiving Services = RS=)

Audiology:	Social Worker:	Home Care:
Medical Specialists:	Public Health Nursing:	Mental Health:
Private OT/PT/SLP:	Help Me Grow/direct website:	Other:

WHEN RETURNING THIS FORM, PLEASE INDICATE ATTACHED INFORMATION (Date:)

☐ *Consent form	☐ Developmental Screening, Assessment Information	☐ Mental Health Screening Assessment Information
☐ Individualized Education Plan / Individualized Family Service Plan		☐ Medical Reports, Diagnosis, Prescriptions
☐ Evaluation results / observations / progress report		☐ Other:
☐ Summary of presenting problems		

RETURN COMMUNICATION (expected within 45 days B-3, 90 days 3-5)

☐ Evaluation in process	☐ Parent declined	☐ No response from parent	☐ Client not seen within 60 days
Result of the assessment: Qualification ☐ Yes ☐ No		Date services started:	
If no, ongoing monitoring? ☐ Yes ☐ No; Follow-up plan			
If yes, describe plan of action/services provided (i.e. frequency, duration, location, and type of service):			
Other relevant details/comments:			
Recommendations to referral source:			

RETURN TO:

☐ Olmsted County Public Health	☐ Help Me Grow	☐ Head Start/School Readiness
☐ Early Childhood Screening (fax: 507-328-4015)	☐ Mayo Clinic	☐ Olmsted Medical Center
☐ Other Medical Provider		

______________ PUBLIC SCHOOLS

BEHAVIORAL HEALTH

Re-Entry to School Referral

Student Name: ____ **DOB:** __________________

School: ____ **Grade:** __________________

Anticipated Date of Return to School: ____

Primary contact person at school: ____

Secondary contact person: ____

Physician/therapist: ____

Phone: ________________________________ **Email:** ___________________________________

THIS SECTION IS ONLY TO BE FILLED OUT BY A PHYSICIAN/THERAPIST

Functional Diagnosis: ____

DSM Diagnosis (optional): ____

Behavioral Health Concerns: ____

____

____

Maladaptive defenses: ____

____

____

Triggers: ____

____

Coping Strategies/ Interventions: ____

____

____

Relaxation/de-escalation techniques preferred /interventions: __________________________

____

____

Medication(s): ____

Date(s) Started: ____

Side Effects: ____

Student/Family reply to questions about absence:

____

____

____

Considerations that may affect academic performance:

____

____

____

____

____

____

Physician/therapist signature ____________________________________ **Date** ____________

I hereby authorize ______________________________ **of** ______________________________
Name *Address/Organization*

and ____________________________________**of** _____________________________________
Name *School Affiliation*

to release information concerning ______________________________ **to one another.**
Name of Student

I also hereby release both parties from all liability and all claims pertaining to the disclosure of this information.

Parent/Guardian Name (Print): ____

Parent/Guardian Signature: ____

Phone: ________________________________ **Email:**_________________________________

_________ **Public Schools person receiving this form:** _________________________________
Signature

Forwarded to: ____ **Date:** ________________
Name/Position