



noe@newleafwc.com | newleafwc.com

New Leaf Wellness Center

10600 Montwood #123

Ph. (915) 313 - 4114

Fx. (915) 313 - 4939

Client Referral Form

Date of Referral: _____

Referral Guidelines

- 1. To refer a potential client, please complete this form and return it via email or fax. You can save this form to your desktop and click "Submit Form" in the upper right hand corner of Adobe Acrobat. The client can also bring this form to their appt.
2. In the event that you may need/want progress reports or clinical updates, please have client or legal guardian sign the release of information also included on this referral form.
3. Initial appointments are scheduled within 3 business days provided there is an available time slot.
4. In the event you feel this person might need urgent services due to suicidal thoughts or erratic behaviors, please call Emergency Health Network for crisis intervention at (915) 887-3410 or dial 911.

Prospective Client Information

Client Name: _____ Date of Birth: _____

Parent/Guardian Name: (minors only) _____

Home Address: _____ Zip Code: _____

Primary Ph. _____ Secondary Ph. _____ Email: _____

Insurance: _____

Why is client referred for services: _____

Referral made by:

Agency: _____

Contact Person: _____ Phone No. _____ Fax No. _____

Email: _____

Do you need confirmation of Appointment? Yes _____ No _____

For New Leaf Wellness use only

Date received: _____ Date of 1st Appt. _____

Initial appointment/Notes: _____

Was referring agency notified: _____



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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Patient's Name: _____

Date of Birth: _____

Parent's Name: _____

(if patient is a minor)

I hereby authorize and allow **New Leaf Wellness Center, their staff and clinicians**; consent to release information on the above named patient regarding services received to:

Agency: _____

Address: _____

This request and authorization applies to written or verbal communication regarding:

Appointment dates and scheduling, attendance, progress notes, treatment plans, and treatment status.

Additional information not listed above: _____

Definition: *This information has been disclosed to you from records whose confidentiality is protected by Federal Law Regulation (42 CFR Part 2) Prohibit you from making any further disclosure without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Any unauthorized disclosure is a federal offense. A general authorization for the release of medical or other information is not sufficient for this purpose.*

I understand once records are released, New Leaf Wellness and staff are not held responsible for any breach of confidentiality due to the transfer or receiving of records to the above named agency/entity/person(s).

I have read or had read to me the above and understand the contents.

Patient or Parent

Signature: _____ Date signed: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER FINAL DATE OF SERVICE.