

INTERCEPT YOUTH SERVICES, INC.  
Youth Quest Anywhere IL Case Management

REFERRAL FORM

<b>Identifying Information</b>			
Referral Date:	DOB:		
Client Name:	SS#:		
Address:	Race:		
Parent/Legal Guardian:	Phone:		
Referring Agent:	Phone:		
Address:	E-Mail:		
Insurance Provider and #:			
<b>Funding Information</b>			
Funding Agency:	Hours needed per week:		
**The above agency agrees to pay the contracted rate for services provided and agreed upon**			
Reason for Referral:			
<b>If available, please provide copies of:</b>			
<input type="checkbox"/> Social History	<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Legal History	<input type="checkbox"/> Current Physical Exam
<input type="checkbox"/> Current Dental Exam	<input type="checkbox"/> Current Medication		

Prescreen Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

Funding Agency Representative: \_\_\_\_\_ Date: \_\_\_\_\_

INTERCEPT YOUTH SERVICES, INC.  
**Authorization for Disclosing and/or Requesting Information**

<b>Client Name:</b>		<b>DOB:</b>		
Intercept Youth Services, Inc. is hereby authorized to:				
<input type="checkbox"/> DISCLOSE/SEND TO THE FOLLOWING PERSON/AGENCY:				
<input type="checkbox"/> REQUEST/RECEIVE FROM THE FOLLOWING PERSON/AGENCY:				
Person/Agency Phone #	Street Address	City	State	Zip Code
<input type="checkbox"/> Case Closing Summary	<input type="checkbox"/> General Health Physical	<input type="checkbox"/> Medication(s) Prescribed		<input type="checkbox"/> Diagnosis
<input type="checkbox"/> Services Received Summary	<input type="checkbox"/> Individual Service Plan	<input type="checkbox"/> Participation & Attendance		<input type="checkbox"/> Social History
<input type="checkbox"/> Evaluation/Assessment	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Legal Information		<input type="checkbox"/> Intake/Referral
<input type="checkbox"/> Psychological Evaluation	<input type="checkbox"/> Educational Records	<input type="checkbox"/>		<input type="checkbox"/>
This authorization is effective beginning // : and will terminate in: <input type="checkbox"/> 90 Days, <input type="checkbox"/> 365 Days (one year), or <input type="checkbox"/> or upon the following date, event or condition:				

The above client is receiving a service through Intercept Youth Services, Inc..

As the person signing this authorization, I understand that I am giving my permission to the above named provider to use, disclose and/or request confidential health care records until the termination of this authorization. I understand this will include information added after the authorization origination date and up until the authorization termination date. I may refuse to sign the authorization. Treatment, payment, healthcare operations or eligibility are not conditional upon giving authorization. The original or a copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. I also understand that I have the right to revoke this authorization at any time, but not retroactive to information already released in accordance with the authorization and that my revocation is not effective until delivered in writing to the person who is in possession of my records. This authorization is automatically revoked upon termination of service.

The person who receives the records to which this authorization pertains may not redisclose them to anyone else without my separate written authorization unless such recipient is a provider who makes a disclosure permitted by law. A general authorization for the release of medical or other information is NOT sufficient authorization. The exact nature of information requested and purpose for which information is sought must be specified. State and/or Federal law protect the disclosed confidential information. Federal Regulation (42 CFR Part 2), restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

\_\_\_\_\_  
 Client Signature Date Signed

\_\_\_\_\_  
 Client's Parent/Guardian or Authorized Representative Signature Date Signed

\_\_\_\_\_  
 Witness Signature Date Signed

**SEND TO THE ATTENTION OF: , Intercept Youth Services.**  
 Richmond FAX: (804) 440-3711

# INTERCEPT YOUTH SERVICES, INC.

HIPAA PRIVACY NOTICE Effective 4/14/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION  
ABOUT YOU MAY BE USED AND DISCLOSED  
AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION  
PLEASE REVIEW IT CAREFULLY

## INTRODUCTION

Intercept Youth Services, Inc. ("Intercept") is required by law to maintain the privacy of Protected Health Information (PHI). This notice provides you with information about your rights and our legal duties and privacy practices with respect to the privacy of PHI. "Protected Health Information" includes any identifiable information that we obtain from you or others that relates to your physical or mental health, the health care you have received, or payment for your health care. This notice also discusses the uses and disclosures we will make of your PHI. We must comply with the provisions of this notice, although we reserve the right to change the terms of this notice and to make the revised notice effective for all PHI we maintain. If we revise the notice, a new notice will be sent to you. You can, at any time, request a copy of our most current privacy notice from your Program Manager or the Intercept Privacy Officer.

## PERMITTED USES AND DISCLOSURES

Intercept is permitted to use or disclose your PHI for purposes of *payment* and *health care operations*.

· *Payment* includes activities we undertake to obtain payment for services rendered. We may use and disclose medical/health information about you so that the treatment and services you receive through Intercept may be billed to and payment received from the appropriate funding sources. For example, we may need to forward treatment progress updates to Family Assessment and Planning Teams (FAPT) in order to receive payment for services rendered.

· *Health care operations* means the activities of Intercept, to the extent that the activities are related to Intercept's operations as a service provider, such as neglect or abuse detection and compliance programs; business management; general administrative activities, including, but not limited to, customer service or resolution of grievances. Intercept is permitted to disclose your PHI to, or receive your PHI from, a provider or another health plan for this purpose, as long as you have a direct relationship with us, as well as with the provider or other health plan.

## OTHER USES AND DISCLOSURES OF PHI

Except for the special circumstances listed below, we will not use or disclose your PHI for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time, provided that the revocation is in writing, except to the extent that we have already taken action in reliance on your authorization.

## SPECIAL CIRCUMSTANCES

Intercept may use or disclose your PHI without your authorization in the following special circumstances:

- As required by law
- Public health activities
- Reports to appropriate authorities concerning victims of abuse, neglect, or domestic violence
- Health oversight activities
- Judicial and administrative proceedings
- Law enforcement purposes
- Regarding decedents for identity, cause of death, or as allowed by law, to coroners, medical examiners, and funeral directors
- Cadaveric organ, eye, or tissue donation
- Research
- To avert serious threat to health or safety
- Specialized Government Function, including national security and intelligence activities
- Worker's Compensation

If your state has a privacy law that provides you greater protections, Intercept will comply with that law.

## YOUR RIGHTS

1. You have the right to request restrictions on our uses and disclosures of PHI for payment and health care operations. However, we are not required to agree to your request.
2. You have the right to make a reasonable request, in writing, to receive communications of PHI, confidentially, by alternative means or at alternative locations.

3. You have the right to inspect and obtain a copy of the PHI that Intercept maintains regarding your medical records that Intercept may use to make decisions about your coverage under the health plan by making a request in writing to the HIPAA Privacy Officer, except for:

- psychotherapy notes;
- information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding;
- PHI obtained from someone other than Intercept under a promise of confidentiality, if the access requested would be reasonably likely to reveal the source of the information.

We also may deny a request for access to PHI if:

- a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger your life or physical safety or that of another person;
- the PHI makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person; or
- the request for access is made by the individual's personal representative and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to you or another person.

If we deny a request for access for any of the three reasons described above, then you have the right to have our denial reviewed. Another health care professional chosen by us will conduct the review.

Intercept is permitted to charge a reasonable fee for copying and mailing the PHI.

4. You have the right to request in writing an amendment to your PHI, but we may deny your request for amendment if we determine that the PHI or record that is the subject of the request:

- was not created by Intercept, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment;
- is not part of your enrollment, payment, claims or other medical records that Intercept may use to make decisions about your coverage under the health plan.
- is accurate and complete.

Any agreed upon amendment will be either attached to or included in your records. Please do not use this formal amendment process for administrative changes such as change of address, change of name, adding or dropping a dependent. We ask that you notify us of those changes through your employer or other routine method.

5. You have the right to request in writing an accounting of disclosures of PHI made by Intercept, within the six years prior to the date of your request, except for disclosures:

- to carry out payment and health care operations as provided above;
- that you authorized or that we made to you;
- that occurred prior to April 14, 2003;
- to persons involved in your care or payment for care;
- as part of a limited data set, as provided in the HIPAA Privacy Rule;
- for national security or intelligence purposes as provided by law;
- to correctional institutions or other custodial law enforcement officials as permitted by the HIPAA Privacy Rule; or
- incident to a use or disclosure required or permitted by the HIPAA Privacy Rule.

6. You have the right to request a paper copy of this notice from Intercept.

7. If you believe that your privacy rights have been violated, you have the right to file a written complaint with Intercept. We will not penalize you for filing a complaint. You also may file a complaint with the Secretary of Health and Human Services.

#### CONTACT PERSON

To file a written complaint, to request access, amendment or accounting, or if you would like further information about this notice, please contact: HIPAA Privacy Officer, Intercept Youth Services, Inc. 5511 Staples Mill Rd. Suite 102 Richmond, VA 23228 Phone # 804-440-3700.

**INTERCEPT YOUTH SERVICES, INC.**  
**Youth Quest Anywhere IL Case Management**  
**Privacy Notice Consent**

I give Intercept Youth Services, Inc. my consent to use or disclose my protected health information to carry out my treatment; to obtain payment from insurance companies; and for health care operations like quality assurance reviews.

I have been informed that I may review Intercept Youth Services, Inc.'s Notice of Privacy Practices for a more complete description of uses and disclosures before signing this consent.

I understand that Intercept Youth Services, Inc. has the right to change their privacy practices and that I may obtain any revised notices at Intercept Youth Services, Inc.

I understand that I have a right to request a restriction of how my protected health information is used. However, I also understand that Intercept Youth Services, Inc. is not required to agree to the request. If Intercept Youth Services agrees to my requested restriction they must follow the restriction(s)

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

\_\_\_\_\_ Date:  
Client Signature

\_\_\_\_\_ Date:  
Guardian Signature

\_\_\_\_\_ Date:  
Witness Signature

**INTERCEPT YOUTH SERVICES, INC.**  
**Youth Quest Anywhere IL Case Management**

**Permission to Transport**

I, \_\_\_\_\_, authorize Intercept Youth Services, Inc. to allow staff to transport \_\_\_\_\_ in their vehicle to activities/events that have been agreed upon as a part of crisis intervention/stabilization services.

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Parent/Guardian Date

**Release of Liability**

I, \_\_\_\_\_, hereby release Intercept Youth Services, Inc. from any and all liability while the child for which I am legal guardian, \_\_\_\_\_ or myself or others allowed by us/me, are in the care of Intercept Youth Services, Inc. I authorize and permit the administration of first aid or access to other medical or psychiatric services in the event of an illness, accident or injury, and release Intercept Youth Services, Inc from liability in case of accident, injury or death.

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Parent/Guardian Date