Leslie A. Campbell, LCSW
Five Tribes Therapy
4075 Park Blvd, Suite 102-361, San Diego, CA 92103
c. 619.820.7770
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REFERRAL FORM

Client Name: ______________________ Date of Referral: ___________________
Date of Birth: ______________________ Phone: ___________________________
Address: ____
____

Referral To: Leslie A. Campbell, LCSW, Five Tribes Therapy, 4075 Park Blvd., Suite 102-361, San Diego, CA 92103, 619.820.7770 – office, www.fivetribestherapy.com, fivetribestherapy@gmail.com

Referral from: ____
Office/Clinic name ____
Presenting Issue: ____
____
____

Please have client sign attached Authorization for Release of Information if consultation is indicated. Thank you!

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Leslie A. Campbell, LCSW, Five Tribes Therapy, to release or obtain information from

____
(Name and contact info)

regarding records obtained during the course of treatment of the following individual

____
(Client name and DOB)

Disclosure of the following PHI (Protected Health Information) is authorized:

☐ Evaluation
☐ History and Physical Examination
☐ Discharge Summary
☐ Progress Notes
☐ Lab Reports
☐ Treatment Plan
☐ Other ____

Disclosure of PHI is required for the following purpose ___________________________
____
____

- I understand that I may revoke this authorization at anytime except to the extent that action has been taken.
- I understand that the information that may be disclosed may include substance and/or mental health treatment.
- Federal law prohibits re-disclosure of this information by the recipient.
- Minor clients and the parents/legal guardian must sign this Authorization.
- A photocopy/fax of this authorization may be accepted in lieu of the original.

Signature of client: ____
Printed name and date: ____