Leslie A. Campbell, LCSW
San Diego, CA 92103
Five Tribes Therapy, a Licensed Clinical Social Worker Corporation
c. 619.820.7770
e. leslie@fiivetribestherapy.com
w. fivetribestherapy.com

REFERRAL FORM

Client Name: _____ Date of Referral: _____
Date of Birth: _____ Phone: _____
Address: _____
_____

Referral To: Leslie A. Campbell, LCSW, Five Tribes Therapy, San Diego, CA 92103, 619.820.7770 – office, www.fivetribestherapy.com, leslie@fivetribestherapy.com

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

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

FIVE TRIBES
THERAPY

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Leslie A. Campbell, LCSW, Five Tribes Therapy, a Licensed Clinical Social Worker Corporation, 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
- ☐ Other _____
- ☐ Progress Notes
- ☐ Lab Reports
- ☐ Treatment Plan

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: _____