REFERRAL TO ALPHA OMEGA INFUSION SERVICES

Instructions: Complete this form and fax it to Alpha Omega Infusion Services at 855-345-9041.

PATIENT INFORMATION

Full Name (First, MI, Last)	Date of Birth	Sex ☐ M ☐ F
Race (if known) ☐ American Indian/Alaskan Native ☐ Hawaiian/Other Pacific Islander ☐ Black/African American ☐ Asian ☐ White		
Ethnicity (if known) Hispanic ☐ Yes ☐ No		
Parent and/or Guardian Full Name if Patient is a Minor (First, MI, Last)		
Home Street Address		
City, State, ZIP, County		
Primary Phone	Other Phone	Primary Language (if known)

REFERRING PROVIDER INFORMATION

Name of Provider Making Referral					
Provider Street Address	City	State	ZIP	Office Phone	Office Fax

PROVIDER REASON FOR REFERRAL

_____

_____

CONSENT TO RELEASE MEDICAL INFORMATION TO REFERRAL PROVIDER FOR AN ADULT. I authorize the provider above to disclose medical information to Alpha Omega Infusion Services relating to my treatment to assist Alpha Omega Infusion Services in performing its duties and/or to coordinate the delivery of services to me. This authorization includes disclosure of information regarding mental illness, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s): _____

I authorize Alpha Omega Infusion Services to disclose my records resulting from this referral with the provider as indicated above. The purpose of the disclosure is to assist Alpha Omega Infusion Services to perform its duties and/or to coordinate services and treatment for me. This authorization includes disclosure described below with the following exception(s): _____

In accordance with the conditions listed on this form, I authorize the use and/or disclosure of my confidential information. Unless revoked, the authorization will remain in effect until the expiration time indicated below. Select only one:

☐ Authorization expires when my treatment with Alpha Omega Infusion Services ends.

☐ Authorization expires as of _____ (specify expiration date).

☐ Authorization expires one year from the date of my signature on this release.

Patient Signature	Date Signed	Printed Name

CONSENT TO RELEASE MEDICAL, DEVELOPMENTAL, AND EDUCATIONAL INFORMATION TO REFERRAL PROVIDER FOR A MINOR. See last page of this form for complete explanation of parental rights regarding consent for minors. I authorize the provider above to disclose medical information to Alpha Omega Infusion Services relating to my child's treatment to assist Alpha Omega Infusion Services in performing its duties and/or to coordinate the delivery of services to my child. This authorization includes disclosure of information regarding developmental disabilities, mental illness, AIDS or AIDS-related illness, and/or HIV test results, with the following exception(s):

_____

I authorize Alpha Omega Infusion Services to disclose my child's records resulting from this referral with the provider as indicated above. The purpose of the disclosure is to assist Alpha Omega Infusion Services to perform its duties and/or to coordinate services and treatment for my child. This authorization includes disclosure described below with the following exception(s): _____

In accordance with the conditions listed on this form, I authorize the use and/or disclosure of my child's confidential information. Unless revoked, the authorization will remain in effect until the expiration time indicated below. Select only one:

☐ Authorization expires when my child's treatment with Alpha Omega Infusion Services ends.

☐ Authorization expires as of _____ (specify expiration date).

☐ Authorization expires one year from the date of my signature on this release.

Parent/Guardian Signature	Date Signed	Printed Name	Indicate Legal Authority of Signor ☐Parent of Minor ☐ Legal Guardian

CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION BETWEEN REFERRAL PROVIDERS AND ALPHA OMEGA INFUSION SERVICES FOR MINORS

Who May Provide Consent?
Parental Consent is not required by Alpha Omega Infusion Services to receive a referral; however, the parent or legal guardian of the child must provide consent for screening, evaluation, and treatment and for disclosure of records. Foster parents **do not** have presumed legal rights to provide parental consent. The consent for release of information on this form authorizes the disclosure and/or use of the child's health or developmental information between the referring provider and Alpha Omega Infusion Services as identified on the referral form.

What Are My Parental Rights?
I have the following rights with respect to this consent:

- You are not required to sign this authorization. Except as permitted under applicable law, refusal to sign will not affect treatment, enrollment, or benefits eligibility.
- You may revoke this consent, in writing, any time except for information already released as a result of this authorization. The written revocation must be given to the organization authorized to release the information.
- You have the right to inspect and, upon paying applicable fees, obtain a copy of the disclosed records.
- The information that you authorize to be released may be redisclosed by the recipient of these records only if allowed by law. If information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.

Why is a Consent Form Important?
Your child might be seen by other professionals who monitor your child's overall growth and development. Your child's health care provider sees your child at well-child visits and for medical treatment. Your child care provider sees your child interact with other children every day. Sometimes your child's health care and other service providers may need more information, like evaluation by other specialists, to best care for your child. The primary goal of this consent form is to allow communication between your child's health care and other service providers and Alpha Omega Infusion Services so these providers can work together to help your child.

What is the Purpose of This Consent Form?
This consent form was developed to ensure compliance with all federal and state laws regarding the protection of medical and educational information. This consent includes the sharing of information as authorized under federal/state confidentiality laws, Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations, and Family Educational Rights and Privacy Act (FERPA) guidelines. The purpose of this consent form is to allow Alpha Omega Infusion Services to ensure the child's health care provider receives information regarding the status of the child being treated. By authorizing Alpha Omega Infusion Services to share pertinent information, you help to ensure that your health care and other service providers remain an active participate in your child's overall health, growth, and development.

How Will This Consent be Used?
This consent form will follow your child's referral to Alpha Omega Infusion Services as he/she is treated. The information generated by this referral will become a part of the child's educational record. Alpha Omega Infusion Services will protect this information as prescribed by HIPAA, FERPA, and other federal/state confidentiality laws.

Family Educational Rights and Privacy Act (FERPA) 34 CFR § 99.30
Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations 45 CFR § 164