JETAPAYEE
SERVICES

(360) 883-5430
(360) 938-8771
help@jetapayee.com
jetapayee.com

Referral Form | New Clients

Date: _____

Referred By: _____

Agency Name: _____

Phone #: _____

Client's Name: _____

Social Security #: _____

Date of Birth: _____

Address: _____

_____

Care Provider: _____

Phone #: _____

Reason for Referral: _____

_____

Physician's Name & Address: _____

_____

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CONSENT FOR EXCHANGE OF INFORMATION

I, _____, authorize discussions, and/or exchange of documents/information between JETA PAYEE SERVICES and

_____

(Person or Agency)

_____

(Address/Phone No.)

PURPOSE OF INFORMATION:

To be able to communicate effectively with people involved in client's financial status, mental health/drug and alcohol treatment.

I UNDERSTAND THAT MY RECORDS ARE PROTECTED UNDER THE FEDERAL AND STATE CONFIDENTIALITY REGULATIONS AND CANNOT BE DISCLOSED WITHOUT MY WRITTEN CONSENT UNLESS OTHERWISE PROVIDED FOR IN THE REGULATIONS.

I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT (E.G., PROBATION, PAROLE, ETC.) AND THAT IN ANY EVENT, THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW.

EXPIRATION DATE: _____

SIGNATURE OF CLIENT: _____

DATE SIGNED: _____

SIGNATURE OF WITNESS: _____