



35 Cottage Street, Norway, ME 04268

Fax Referral Line: (207) 739-6110

Program Cell: (207) 890-5721

Email Referral Form to:  
[jamieshead@progresscentermaine.org](mailto:jamieshead@progresscentermaine.org)

**Patient Referral Form**

Patient Name		Date of Referral	
Age	Date of Birth	Gender	Male Female
Street Address		City / Town	
Cell Phone		Home Phone	
E-Mail Address			

Other Household Members:

Name	Age	Relationship	Comments
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Name	Age	Relationship	Comments
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Name / Phone  
 Number of Person  
 Filling out Form

Referring Physician / Provider	Phone	Fax
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Reason for Referral

Primary Diagnosis	Secondary Diagnosis
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Food Allergies	Dietary Restrictions
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Diet Recommendations	Is patient malnourished or at risk of malnourishment?	yes no
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35 Cottage St., Norway, ME 04268

Main: (207) 743-8049

Fax: (207) 739-6110

### Release of Information

Full Name:

Date of Birth:

I hereby request and authorize staff employed by The Progress Center, Inc. to use or disclose the individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization/individual authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Information to be: (Please check both boxes)	released to obtained from	Provider or Practice Name
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Description of Information to be released: (check all that apply)

Diagnosis & Treatment	Other:	Please Specify:
Discharge Plan		
Assessment / Evaluation		

Purpose of Release:

Coordination of home delivery meal services

I understand that the information indicated above is protected by law and cannot be released without permission, unless otherwise required by law. I further understand that I may review my records and refuse authorization to disclose all or some of the above health information, but refusal may result in discharge from the home meal program. I may receive a copy of my records.

Information regarding alcohol/drug use or abuse, mental health and/or HIV or AIDS is often necessary to coordinate quality services. By initialing below, you give consent to release the following:

Alcohol / drug use or abuse records  
Mental Health records  
HIV / AIDS diagnosis / treatment records

I understand that this authorization will expire on the following date \_\_\_\_\_ (not to exceed 1 year from date signed), or upon termination of services. I may revoke this authorization by notifying The Progress Center at any time, except where The Progress Center has already acted upon a request for the release of my health information.

The Progress Center will not receive payment for the use of the information disclosed.

I authorize The Progress Center staff to communicate information regarding my case via email and fax:

Yes  
No

I understand that I am entitled to a copy of this form.	Client received copy:	Yes No, declined
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Patient Signature

Date: