THE PROGRESS CENTER, INC.

community, opportunity, growth.

35 Cottage Street, Norway, ME 04268 | Fax Referral Line: (207) 739-6110 | Program Cell: (207) 890-5721

Email Referral Form to: jenniferputnam@progresscentermaine.org

Patient Referral Form
Home Meal Delivery Program

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
Name	Age	Relationship	Comments

Referring Physician / Provider | Phone | Fax

Reason for Referral

Primary Diagnosis | Secondary Diagnosis

Food Allergies | Dietary Restrictions

Diet Recommendations | Is patient malnourished? yes / no

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

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

Patient Signature Date: