THE PROGRESS CENTER, INC.
community. opportunity. growth.

Feel Better Food
Brought to you by The Progress Center, Inc.

Patient Referral Form

Fax Referral: (207) 539-6395
Contact: Liz Blaquiere: (207) 890-5721

Patient Name | Program: ☐ Adults: Patient Meal Delivery | Date of Referral

Age | Date of Birth | Gender ○ Male ○ Female

Street Address | City / Town

Cell Phone | Home Phone

Other Household Members:

Name	Age	Relationship	Comments

Name / Phone Number of Person Filling out Form | If patient is a minor Parent Name:

Referring Physician / Provider | Phone | Fax

Reason for Referral

Primary Diagnosis | Secondary Diagnosis

Food Allergies | Dietary Restrictions

Diet Recommendations | Is patient malnourished or at risk of malnourishment? ○ yes ○ no

THE PROGRESS CENTER, INC.
community. opportunity. growth.

35 Cottage St., Norway, ME 04268 Main: (207) 743-8049 Fax: (207) 739-1114

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
☐ Discharge Plan
☐ Assessment / Evaluation

Other: ☐

Please Specify: _____

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 or Parent / Guardian if Patient is a minor Signature _____ Date: _____