MYgroup
McLAUGHLIN YOUNG

Student Formal Referral Form

Administrator & Student Information

School:		Referral Date:	
Student Name:		Student Phone:	
Administrator Name:		Administrator Title:	
Administrator Phone:		Confidential Voicemail?	☐ Yes ☐ No
Administrator Email:			

Reason for Referral

Please indicate the reason(s) for the referral and attach any additional documentation.

Performance Goals

Have the issues indicated on this form been discussed with the student?	☐ Yes	☐ No
What are the consequences if this student's performance does not improve?		
Have the consequences for not improving been discussed with the student?	☐ Yes	☐ No
How will the student's improvement be measured?		
How long will the student be given to make the desired changes?		

Student Signature

I understand that my school administrator is referring me to the Student Assistance Program. My signature verifies that I have seen this form. My signature below does not signify my agreement or disagreement with any of the issues raised.			
☐	Yes, I will participate in and cooperate with the Student Assistance Program.		
☐	No, I will not participate in and cooperate with the Student Assistance Program.		
Student Signature:	SIGN HERE	Date:	

Please email this completed form to: formalreferral@mygroup.hush.com

If you prefer to fax, please send to 704.529.5917 to the Attn: Formal Referral Coordinator

MYgroup
McLAUGHLIN YOUNG

Authorization of Release of Client Records

Client Name:	Date of Birth:
I request and authorize McLaughlin Young Employee Services (MYgroup) to:	
☑ Release the following information to:	☑ Receive the following information from:
Name of Facility/Peson:	
Address:	
Phone:	Email:

Release is for the purpose of:

- ☐ Continued care by the other provider
- ☐ Attorney
- ☐ Disability
- ☑ Formal referral
- ☐ Personal review
- ☐ Other (please specify):

Information to be disclosed if requested:

- ☑ Service dates
- ☐ Session constellation
- ☐ Session participants
- ☐ Clinical assessments
- ☑ Summary of treatment
- ☐ Other (please specify):

I understand that the information I am authorizing to be released may include mental health information and any therapy constellation (individual, couple, family, group) in which I have participated.

I further understand that this Authorization is voluntary, and I may refuse to sign this Authorization. I further understand that my treatment will not be affected if I do not sign this form (45 CFR 164.508(c)(2)).

I further understand that I may revoke this Authorization at any time by notifying MYgroup (or the releasing facility) in writing by certified mail, return receipt requested to the CEO of MYgroup, except to the extent that actions have been taken in reliance on it. Any such revocation shall not be effective until the next business day following receipt of the revocation notice by MYgroup. Unless earlier revoked, this Authorization automatically expires one year from the day signed or one year after the last MYgroup visit (45 CFR 164.508(c)(2)).

I further understand that if I refuse to authorize the release of information in a situation where the information is needed by the Employer for legal or other reasons of business necessity, it may limit MYgroup's ability to continue to provide services in which case MYgroup may make a referral to another healthcare provider. Any person or other entity who receives information pursuant to this authorization should not redisclose this information to anyone else.

I further understand that the person(s) I am authorizing to use or disclose my information may receive compensation (either directly or indirectly) for doing so.

Release from Liability: I release and agree to hold harmless MYgroup (or other releasing facility) and its agents, representatives, and employees from any and all liability association with the release of confidential client information in accord with this Authorization. I understand that MYgroup (or the releasing facility) cannot be responsible for use or redisclosure of information to third parties (45 CFR 164.508(c)(2)).

To the Receiving Party of this Information: This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the client is prohibited. These records may be protected by federal regulation (42 CFR Part 2).

I certify that this was fully explained to me; I have read it or had it read to me;* and I understand its contents.

Print Client Name/Legally Authorized Person:	Signature: SIGN HERE	Date:
Print Witness/Translator* Name:	Signature: WITNESS	Date:

Dear Student,

You will need to contact your Student Assistance Program, MYgroup, at 800.633.3353, and let them know you have been formally referred by your school administrator. Please read this letter carefully and keep it for future reference.

The clinician at MYgroup will:

1. Explain your rights to confidentiality.
2. Inform you that only two pieces of information (attendance and compliance) will be shared with the specified person and everything else will remain confidential.
3. Refer you to a clinician in your area who will meet with you and assess your situation.

The clinician in your area will meet with you more than once to thoroughly assess your situation or progress. These sessions will be confidential, and there will be no cost to you for your Student Assistance Program visits.

The treatment recommendations the clinician makes must be followed. The recommended plan of action may exceed the services covered by the Student Assistance Program and could mean some out-of-pocket expense for you. In many cases, your health insurance will pay for treatment.

Please call us with any questions or concerns you may have. We are here to assist you.

Sincerely,

Formal Referral Coordinator
MYgroup