Catalpa Health Authorization of Release of Confidential Information

General content of documents to be released to an outside source

*Please note the list below is not all-inclusive and may vary amongst providers

☐ Diagnostic Evaluation/Intake Assessment	☐ Diagnosis	☐ Pupil and Educational Records
☐ Progress Notes	☐ Medications/Dosage Instructions	☐ Completion of Behavioral Questionnaires
☐ Discharge Summary	☐ Neuro/Psychological Evaluation	☐ Labs/Imaging Results
☐ Treatment Plan/Goals	☐ Behavioral Health Records	☐ Attendance/Appointment Information

☐ Other:_____

Diagnostic Evaluation/Intake Assessment (First meeting)

Client presenting issue and current mental health symptoms
Client's history of presenting issue and past symptoms (also includes significant life events)
Client treatment history (counseling , psychiatric hospitalizations, testing, etc)
Family medical and mental health/AODA history
Developmental and birth history
Client history of medications
Social and Educational history and current status
Preliminary diagnoses
Safety assessment
Clinical impressions and recommendations for care

Progress Note (follow up meetings)

Current functioning (includes symptoms as well as social, family and educational information)
Interventions applied in clinical session
Clinical impression of client's current functioning related to treatment episode
Plan for after the clinical session (interventions to self-apply, family support, safety plan, other actions to support treatment direction)
Treating diagnosis
*Medication prescribed if for Psychiatry

Discharge Summary

A Summary of the client's treatment containing such information as the start and end dates, number of visits attended, progress in treatment, reason for discharge, prognosis, discharge diagnosis, referrals made post-discharge, and return to care instructions, if any

Treatment Plan/Goals

Treating Diagnoses
Short term and long term goals for treatment (may be individual goals and/or family goals)
General interventions to be used and ways to measure progress
Plans for connecting with other service lines or care teams (testing, medication, therapy, school, etc)
This is a document that requires a signature from a primary caregiver/legal representative

Diagnosis

A cluster of symptoms client demonstrates through behaviors and self/caregiver report. All diagnoses are from the same diagnostic manual (DSM-5). Examples are Generalized Anxiety, Major Depression and ADHD.

Medications/Dosage

Instructions for medications (type and dosage) prescribed by a psychiatric provider (MD, DO or APNP)
Instructions on when and amount (dosage) the medication is to be taken

Neuro/Psychological Evaluation

Information gathered from clinical interview, medical record review, and educational records
Results of testing and behavioral report inventories (may include test scores)
Clinical impressions, diagnoses, and recommendations to support client

Behavioral Health Records

Information shared may include information related to mental/behavioral health

Pupil and Educational Records

Information shared by the school related to a client's academic performance and behavior in the school

Completion of Behavioral Questionnaires

Assessment tool based on behavioral observation, commonly sent to teachers and parents/caregivers

Labs/Imaging Results

Report from a Radiologist (Physician) explaining imaging findings
Lab values as well as dates and times labs were performed

Attendance/Appointment Information

Information about the client's attendance to appointments scheduled at Catalpa such as dates, times and the name of the provider the appointment was scheduled with