503.597.3992 | ComfortZoneNN.org

10130 SW Nimbus Ave, Suite D2, Tigard, OR 97223



A Peer Program of

**Participant Natural Support:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Care Coordinator:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Organization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Which of Comfort Zone's offerings best align with the participant's needs?**

❏ Peer Specialist Support (1:1 conversations) ❏ Community Activities

❏ Systems Navigation (applications/resource finding) ❏ Nutrition (in-house food pantry)

❏ Intentional Growth (skill building) ❏ Wellness Groups/Affinities (Queer/Hearing Voices/Alt2Suicide)

**Please list any safety concerns or accommodation needs that best support the participant:**

**Name of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pronouns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Does Participant identify as any of the following:**

**Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❏ 2SLBGTQIA+/Queer ❏ BIPOC**

**County of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ❏ Immigrant/Migrate ❏ Houseless**

Comfort Zone Referral Form

**How to refer to Comfort Zone:**

Please complete the information below and email this form via secure email to [ComfortZone@NewNarrativePDX.org](mailto:ComfortZone@NewNarrativePDX.org).

**Criteria for Comfort Zone:**

We are a low-barrier program and accept anyone regardless of insurance or diagnosis, keeping in mind that this is a Family Friendly location. To be considered for Comfort Zone, please ensure the participant consensually identifies with a need for Peer Services.

**Expiration Criteria** – Indicate below:

❏ 30 days after discharge from service ❏ 1 year from today’s date Date/Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that medical records are protected under the Federal regulations governing Confidentiality of Patient Records (Health Insurance Portability and Accountability Act of 1996) I understand that substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIP AA), 45 C.F.R. pts 160 & 164. These records cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it.

You may choose not to sign this form. The provision of services will not be withheld if you do not sign this form. However, not signing this form could negatively impact your services if the form is necessary for eligibility verification or coordination

of services.

A copy of this document has been offered to me: ❏ Yes ❏ No

**Purpose of disclosure**

❏ Care Coordination/Bridging Services ❏ Engagement/Follow-up ❏ Resource Connection

❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❏ Diagnosis ❏ Presence in Program ❏ Progress towards goals

❏ Medication ❏ Referral Information ❏ Coordination and resource needs

❏ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client/Representative Signature Date Witness/Staff Signature Date**

This information has been disclosed to you from records protected by federal confidentiality rules (42 CPR part 2).

The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see§ 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at§§ 2.12(c)(5) and 2.65.(b) [Reserved]

Mental Health Medical Health Substance Use

**Participant Name:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **DOB**: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I authorize Comfort Zone/New Narrative for the mutual exchange of information with:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information to be disclosed –** Please initial individual information categories to be shared

Authorization for Use and Disclosure of Health Information

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