



PROVIDERS FOR HEALTHY LIVING

Child, Adolescent, and Adult Psychiatry & Therapy Services

phone & fax **614-664-3595**

8351 N High Street, Suite 155, Columbus, OH 43235

TELEMEDICINE TREATMENT REFERRAL FORM

Patient Name: _____

Date of Birth: _____

Providers for Healthy Living has either diagnosed and/or will be treating this person for their behavioral health condition. Due to the changes in the Public Health Emergency (PHE) effective 11/11/2024, we are asking you to complete and sign this form so that we can provide uninterrupted care to our mutual patient to satisfy the requirements of the Ryan Haight Act.

In doing so, please complete the following information and acknowledge the following:

1. Based on my most recent in-person exam, I clear this patient for treatment with controlled substances, if needed.
2. The patient is referred to Providers for Healthy Living for behavioral health treatment.

If you feel there is any pertinent information to share with our medical providers, please include it with the submission of this form.

Provider Name and Credentials: _____

Provider NPI: _____

Practice Name: _____

Signature of Provider: _____

Date Signed: _____

When completed, send this form to patient@providersforhealthyliving.com or fax it to 614-664-3595. We appreciate your support!