Fax Referral To:
901-388-0407

www.restorerx.com

RestoreRx

Vivitrol Enrollment Form

Ship to:
☐ Office
☐ Care Site
Other:

Phone: 877-388-0507

PATIENT INFORMATION

Complete the following or send patient demographics sheet					
Patient Name:					
Address:					
City State Zip:					
Home Phone:					
Cell Phone:					
Allergies:					
Date of Birth:		Gender:			

Medical Insurance							
Prescription Card:	ID:		BIN:		PCN:	Group:	
Secondary:	ID:		Name of Insurer:			Phone:	
	ID:		Name of Insurer:			Phone:	

PRESCRIBER INFORMATION

Prescriber Name:	Richard Poehlein, MD		
DEA#:	BP9185198	NPI#:	1831186493
Supervising MD:		NPI#:	
Facility Name:	Westbrook Medical Center		
Address:	930 Adell Ree Park Lane		
City, State, Zip:	Knoxville, TN 37909		
Phone:	865-769-2600	Fax:	865-769-2616
Contact Person:	Lucy Spurgeon	Phone:	865-769-2600

DIAGNOSIS INFORMATION: ☐ Alcohol Dependence ☐ Opioid Dependence **Diagnosis Code:** F10.____ F11.____

PRESCRIPTION STATUS: ☐ New ☐ Reauthorization ☐ Restart

PRESCRIPTION and PRIOR AUTHORIZATION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	FREQUENCY	QUANTITY	REFILLS
☐ **Vivitrol Kit** (includes medication, diluent, administration supplies)	☐ 380mg	Prescriber to inject contents of one vial intramuscularly	☐ every 28 days	#1	

Patient has failed the following oral therapies ☐ Acamprosate ☐ Naltrexone ☐ Disulfiram

Is the patient in eminent danger/at risk if medication is not approved? ☐ Yes ☐ No

Does the patient currently drink alcohol? ☐ Yes ☐ No

Is the patient currently taking any opioids for pain management? ☐ Yes, Specify _____ ☐ No

Has the patient been opioid free for a minimum of 7-10 days prior to therapy initiation? ☐ Yes ☐ No

Does the patient have documentation of a recent urine drug screen? ☐ Yes, Date _____ ☐ No

Is the patient currently in a comprehensive treatment plan that includes psychosocial support? ☐ Yes ☐ No

Has the patient been screened for hepatitis/liver failure? ☐ Yes ☐ No
PLEASE ATTACH LAB RESULTS

My signature below authorizes Restore Rx Specialty Pharmacy staff to act as my authorized agent to complete the insurance prior authorization process for my patient listed above. My authorization shall include any required signatures by Restore Rx Specialty Pharmacists on my behalf to facilitate this process and acknowledge their authorized access to necessary healthcare data to complete said processes.

Dr. Richard Poehlein
Physician Signature

Date

This prescription will be filled generically unless prescriber writes "DAW" in the box to the right

DAW

Westbrook Medical Center, PLLC

930 Adell Ree Park Lane, Knoxville, TN 37909 865/769-2600 Fax 865/769-2616

Vivitrol (Naltrexone) Treatment Agreement

Please initial each statement below.

_____ 1. I understand that Vivitrol is currently indicated and approved for alcohol and opioid dependency.

_____ 2. I understand that the recommended treatment program for recovery is twelve to eighteen months in the majority of cases.

_____ 3. I understand that I should be free from using Methadone for a minimum of two (2) weeks or the time decided by my Provider prior to the first Naltrexone injection.

_____ 4. I understand that I need to be opiate free for 7-10 days including legal painkillers such as Hydrocodone, Morphine, Fentanyl, or others, and any and all illegal substances such as heroin, THC, etc. I also understand that if I have been using buprenorphine (Suboxone), I need to be off of it for at least 7-10 days.

_____ 5. I understand that I may experience acute opiate withdrawal if I still have opiates in my system.

_____ 6. I understand that I should not be on a Naltrexone product if I have acute infectious Hepatitis.

_____ 7. I understand that the risks of being on naltrexone during pregnancy are unknown, and therefore it is my responsibility to have an ADEQUATE BIRTH CONTROL METHOD. If I become pregnant, I understand that Vivitrol will be stopped immediately.

_____ 8. I understand this office may perform drug screens (observed or non-observed) on all patients receiving Vivitrol. The patient is responsible for a nurse visit charge. This sample may be referred to an outside lab or tested in house and the patient and/or the insurance company will receive a bill. Patient agrees to report to this office for random drug screens within two hours of being called. If the patient is out of town when called for a drug screen, the patient must bring in proof of their whereabouts at the time of the call (a credit card receipt which is time and date stamped with the Patient's name on it or a notarized statement from an official entity). Failure to comply can result in immediate dismissal of care.

_____ 9. I understand that once injected, Vivitrol is deposited in the muscle tissue for up to one month and cannot be removed.

_____ 10. I understand that if I take opiates after having the Vivitrol injection, I will NOT feel their effects by getting high or having any pain control – BUT I COULD HAVE ACCIDENTAL OVERDOSE AND DIE.

_____ 11. I understand that I may experience symptoms such as nausea, vomiting and/or abdominal pain if I consume alcohol less than one week before the first naltrexone injection.

_____ 12. Because the consumption of alcohol, opiates or any mood altering substance, whether legal or illegal, (i.e. THC, marijuana, CBD with THC, any opiate, or any alcoholic substance) may convince the patient to return to their former use of those substances, I agree to abstain from all mood altering substances.

_____ 13. The use of any illegal substance, including, but not limited to, marijuana, cocaine, crystal-meth, LSD, PCP, anabolic steroids, etc. can result in immediate dismissal from care.

_____ 14. I understand that if I sustain an injury which might require treatment with an opiate, it may be more difficult to treat my pain because naltrexone will block the brain's opiate receptors. I agree to inform any treating provider that I am a Vivitrol patient.

_____ 15. I understand that if I attempt to override the opiate receptor blockage with opiates, I run the risk of ACCIDENTAL OVERDOSE AND DEATH.

_____ 16. I understand there can be potential side effects of the injection such as nausea, vomiting, headache, dizziness, and swelling, pain or discomfort at the injection site.

_____ 17. I understand that I will have blood tests done to assess the effects of opiate use on my body. The tests may include HIV, Hepatitis, lipids, etc. I understand that these tests will be sent to an outside lab and I will be billed separately for these tests.

_____ 18. I understand that I must participate in counseling in order to obtain the maximum benefit from treatment with Vivitrol. I will complete these counseling sessions here at Westbrook.

_____ 19. I understand there is a risk of severe injection site infection and I will contact the office should this occur.

_____ 20. I understand that I should carry a bracelet, necklace or written information with me at all times to alert healthcare providers that I am taking Vivitrol so I can be treated properly in an emergency. I will notify all my providers that I am in an addiction treatment program and that I should not receive any opiate medication or any mood altering substance.

_____ 21. I understand that my behavior towards the staff at this office must be respectful and acceptable at all times.

_____ 22. I agree to immediately notify the office of any change of address and/or telephone number. All patients must be accessible to this office at any time when this office needs to contact them. Voice mail must be set up and checked. If this office cannot reach the Patient, this office has a right to discharge the patient without further notice.

_____ 23. This office has permission to request information on a patient's history and/or care from <u>any</u> source (pharmacy, physician's office, hospital, family member, significant other, etc.).

_____ 24. All Prescribing Provider's orders and recommendations must be followed (exp: therapy, office visits, diagnostic tests, etc.) to remain under care.

_____ 25. If a patient is late for an appointment (fifteen minutes), the office is under no obligation to see the Patient on that date.

The rules of this agreement are rigid; however, they are intended to protect our patients while in a recovery program and are essential to allow this office to effectively treat addiction.

<u>AGREEMENT:</u>

I have read the above agreement, initialed each item, and understand the rules regarding the Vivitrol program. I agree to fully comply with this Agreement.

Date _____

_____
Patient Printed Name

_____
Patient Signature

_____
Staff Witness

Kessler Psychological Distress Scale (K6)

Family name	Given Names	File No.
Address	Date of assessment (yyyy-mm-dd)	Date of birth (yyyy-mm-dd)

Protected when completed.

The Kessler Psychological Distress Scale (K6)[1] is a simple measure of psychological distress which involves 6 questions about a person's emotional state. Each question is scored from 0 (None of the time) to 4 (All of the time). Scores of the 6 questions are then summed, yielding a minimum score of 0 and a maximum score of 24. Low scores indicate low levels of psychological distress and high scores indicate high levels of psychological distress.

The following questions are about how you have been feeling during the **past 30 days**.	ALL	MOST	SOME	A LITTLE	NONE	(IF VOL) DON'T KNOW	(IF VOL) REFUSED
1. About how often during the past 30 days did you feel **nervous** - would you say **all** of the time, **most** of the time, **some** of the time, a **little** of the time, or **none** of the time?	O	O	O	O	O	O	O
2. During the past 30 days, about how often did you feel **hopeless** - **all** of the time, **most** of the time, **some** of the time, a **little** of the time, or **none** of the time?	O	O	O	O	O	O	O
3. During the past 30 days, about how often did you feel **restless or fidgety**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
4. How often did you feel **so depressed that nothing could cheer you up**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
5. During the past 30 days, about how often did you feel that **everything was an effort**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O
6. During the past 30 days, about how often did you feel **worthless**? (IF NEC: **all, most, some, a little,** or **none** of the time?)	O	O	O	O	O	O	O

[1]Source: Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J., Normand, S.L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. Archives of General Psychiatry. 60(2):184-9.

Name of assessor	Professional designation	Date (yyyy-mm-dd)

Patient Name Date:

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Place an X in one box that best describes your answer to each question.

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

NAME_____ DATE_____

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.			
In the past 12 months...		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes".			**Score:**

Staff member validating score_____ Date _____

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

New policy effective 07/01/2020

Please list below all individuals living in your household

Patient Full Name _____ **DOB** _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

Full name _____ DOB _____

Relationship to patient _____

REGISTRATION FORM

Date_____

Patient Name_____
Last First Middle Suffix
Sex: Male_____ Female_____ Patient's Social Security Number_____
Birth date _____Single ___ Divorced ___ Married ___ Widowed ___ Separated ___

Home Street Address_____
City_____State_____Zip_____
Home Phone (_____)_____ Cell Phone (_____)_____
Cell Phone Company_____ email address _____
Name of Primary Care Physician_____ Phone #_____
Referral Source_____ Patient's Driver's License Number_____
PHARMACY Pharmacy Name, Address, and Phone Number _____
_____

EMPLOYER OF PATIENT (or Guardian if patient is minor)
Company Name_____
Address_____
City _____State _____Zip_____
Occupation _____ Phone Number(_____)_____

Circle appropriate answer:
Race: American Indian Asian Black Caucasian Other Declined
Ethnicity: Hispanic Non-hispanic Declined

Primary Language Spoken_____

Name of Parent or Guardian (if patient is a minor)_____
Date of birth of Guardian_____ SSN of Guardian _____
Driver's License # of Guardian_____

SPOUSE OF PATIENT (or Guardian if patient is minor)
Name_____
Birthdate _____Social Security Number_____
Employer Name_____
Address_____
City_____State_____Zip_____Phone_____

REASON FOR VISIT
Condition related to: Illness_____ Well visit_____Accident_____
Other_____ Date of Accident, if applicable_____

INSURANCE INFORMATION
Insurance Company_____
Insured Name _____Relationship to Patient_____
Group or Policy Number_____ ID #_____

Westbrook Medical Center
930 Adell Ree Park Lane
Knoxville, TN 37909

PATIENT HEALTH QUESTIONNAIRE

Patient Name_____ DOB_____

Review of Systems: (Check all that apply)

Head & Neck
___ Eye Disease
___ Double vision
___ Blurred vision
___ Prior-Ear Surgery
___ Ear Ache
___ Hearing loss
___ Dizziness
___ Nosebleeds
___ Sinusitis
___ Allergies
___ Nasal Polyps
___ Snoring
___ Excessive sleepiness
___ Facial pain
___ Pain with chewing
___ Lumps in the neck

Respiratory System
___ Hoarseness
___ Chronic cough
___ Coughing up blood
___ Shortness of breath
___ Wheezing
___ Asthma
___ Chronic bronchitis
___ Emphysema
___ Tuberculosis
___ Lung cancer

Endocrine
___ Diabetes
___ Thyroid imbalance
___ Menstrual disorder

General
___ Night Sweats
___ Fevers
___ Skin diseases
___ Arthritis
___ Bleeding Disorder
___ Bruising Easily
___ HIV infection or AIDS
___ Psychiatric Diseases
___ Weight Loss
___ Depression
___ Anxiety
___ Bipolar Disease
___ Suicidal Thoughts

Neurologic
___ Headaches
___ Numbness or tingling
___ Transient vision loss
___ Seizures
___ Back pain
___ Muscle Pain
___ Strokes

Cardiovascular
___ Hypertension
___ Heart disease
___ Chest pain w/exertion
___ Swelling of the ankles
___ Heart surgery
___ Pacemaker
___ Anemia

Gastrointestinal
___ Difficult swallowing
___ Diarrhea
___ Constipation
___ Jaundice
___ Liver disease
___ Hepatitis
___ Kidney Disease
___ Bloody stools
___ Diverticulosis
___ Gall bladder disease
___ Heartburn or ulcers
___ Nausea/Vomiting
___ Black Stools

Urologic
___ Difficulty on urination
___ Frequent urination
___ Blood in the urine
___ Prostate problems

Other
_____

Past and present medical problems:

Previous surgeries and dates (month/year)

List all current medications and dosages (including OTC):

Do you smoke?
___ Yes ___ No
If yes, how much ?_____

Do you drink alcohol?
___ Yes ___ No
If yes, how much ?_____

Please list all allergies: _____

Patient Signature_____ Date_____

ASSIGNMENT – AUTHORIZATION & LIEN

I hereby irrevocably authorize and direct my insurance company, my attorney, and/or any third party payers to pay directly to the provider, Westbrook Medical Center, PLLC, all sums of money due for any and all services rendered to me (or a minor child for which I m responsible) by reason of accident, illness or any and all reasons. I further direct said insurance company, attorney, or third party payer to withhold such sums from any payment, including but not limited to health and accident benefits, disability benefits, workers' compensation benefits, medical payment benefits, no fault benefits, foundation grants, government or agency benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately provide for any financial obligation owed this office and assignees.

I further agree that this agreement acts as an assignment of my rights and benefits to the extent this office rendered services; therefore if my insurance company and/or attorney obligated to make payment to me for the charges incurred at this office refuse to make such payment, I hereby assign and transfer to this office and assignee any and all causes of action that I might have or that might exist in my favor against such company and authorize this office and assignee to prosecute said cause of action either in my name or in the assignee's name. This office is also authorized to settle or otherwise resolve said claim or cause of action as they see fit. I understand that this does not relieve me of my personal responsibilities for all such charges in the event there is no recovery or if the recovery is insufficient to satisfy such charges. I hereby agree to give a full lien to said office against any and all insurance benefits named herein, or any and all proceeds of any settlement, judgment or verdict which may be paid to me as a result of injuries or illness for which I have been treated by said office and assignees. I further agree that the assignee's right for payment shall not be bound by a statute of limitations until a reasonable time has lapsed after either negotiations or litigation between third parties and myself are resolved. A photocopy of this assignment shall be considered as effective and valid as the original. I voluntarily waive the statute of limitations regarding my doctors and/or this office's rights to recover and, and I agree to be held fully responsible for all debts I incur in this office.

It is further agreed that I shall remain personally responsible for the total amount due this office and assignee for its services. I further understand and agree that this Assignment, Authorization, and Lien does not constitute any consideration for the office to wait for payment(s) and that they may demand full payment from me immediately and at any time upon rendering service at their option. Such option requires that I pay for all sums due and owing in full within ten (10) days of demand. I further understand that a monthly service charge is computed by a periodic rate of 1% per month which is an annual percentage rate of 12% applied to the previous balance after deducting current payments and that the service charge may change without notice. I understand that all money due this office will be paid in a timely manner with no amount of money due past 90 days from the date of service, regardless of attorney liens, representations of any attorney, pending settlement(s) or other matters unless approved in writing by this office in advance of the 90 day limit. I further agree and understand that, if the need arises, accounts delinquent may be placed for collection and that I am fully responsible for all court costs, filing fees, attorney costs, and all associated collection costs.

I further understand and agree that, as necessary, this office and its staff may submit, prepare or complete medical records, consultations, depositions and/or court appearances on my behalf which I understand must be paid in full in advance and are not considered part of my account. I authorize this office to release any information pertinent to my case to any insurance company, adjuster, attorney or legal service bureau to facilitate collections under the terms of this document. I agree that Westbrook Medical Center, PLLC is given full power of attorney to endorse and/or sign my name on any and all checks for payment of any indebtedness owed this office and assignee. I understand that this office, the doctors and the staff are accepting my case based on examination findings and believe the outlined treatment should produce change and/or improvement. However, as with any doctor's treatment, a guarantee of improvement or complete recovery cannot be made and it is even possible that no change will occur. I do agree that I am fully obligated to pay for all charges for all services rendered to me.

Print Name_____

Signature _____ Date _____

Westbrook Medical Center

"Consent for Purposes of Treatment, Payment & Healthcare Operations"

(In this document, "I" and "my" refer to the patient, and "facility" refers to Westbrook Medical.)

I consent to the use or disclosure of my protected health information by Westbrook Medical Center for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Westbrook Medical Center. I understand that analysis, diagnosis or treatment of me by this facility may be conditioned upon my consent which is evidenced by my signature below. Diagnostic testing may be required so a thorough analysis can be completed.

I understand that payment is due at the time services are rendered unless other arrangements have been approved in advance by the staff. I understand that Westbrook Medical Center may accept insurance assignments when the insurance coverage is through a group with whom they participate. If applicable, my consent for an assignment of my benefits to Westbrook Medical Center is designated by my signature below. Deductibles and co-payments must be honored at the time services are rendered. A finance charge will be added to outstanding balances. I understand that Westbrook Medical Center accepts cash, Visa, and MasterCard.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Westbrook Medical Center is not required to agree to the restrictions that I may request. However, If Westbrook Medical Center agrees to a restriction that I request, the restriction is binding to the facility.

I have to right to revoke this consent, in writing, at any time, except to the extent that Westbrook Medical Center has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition.

_____
Signature of Patient or Representative

_____
Print Name of Patient or Representative

_____
Date of Signing

_____
Description of Representative's Authority

CONSENT FOR PATIENT TESTING AFTER HEALTHCARE WORKER EXPOSURE

Westbrook Medical Center health care workers handle blood and other body fluids for many reasons such as when performing lab tests and cleaning equipment. It is the policy of Westbrook Health Center to test a patient for Hepatitis B, Hepatitis C and HIV (the virus that causes AIDS) if any employee or health care worker is exposed to a patient's blood or other body fluid in such a way that transmission of these infections could occur. Should an accidental exposure occur, the tests would be conducted at no cost to you. We are requesting that you consent to these tests prior to treatment. My signature below indicates my consent to test my blood or body fluid for Hepatitis B. Hepatitis C, or HIV.

_____
Signature of Patient or Representative

_____
Date

I decline to authorize the above testing:

_____
Signature of Patient or Representative

_____
Date

WESTBROOK MEDICAL CENTER

930 Adell Ree Park Lane
KNOXVILLE, TN 37909
(865) 769-2600
865/769-2616 FAX

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I _____ authorize Westbrook Medical Center located at the address above to receive my medical history information or treatment records from any source needed to enhance my care with their facility.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated by providers at this facility unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the facility specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Unless otherwise specified, please release ALL records related to my care.

_____ Printed name of Patient

_____ Patient Date of Birth

_____ Patient Social Security Number

_____ Patient Signature

_____ Patient Signature Date

If you have received this form in error, please notify the above office immediately.

Please fax records as soon as possible unless noted otherwise.

Note: Faxed to _____ *at fax #* _____
FACILITY/PROVIDER *NUMBER*

WESTBROOK MEDICAL CENTER

Authorization for Medical Care

COMPLETE THIS SECTION IF PATIENT IS BELOW 18 YEARS OF AGE:

I _____authorize the following people to bring my child_____ Birthdate_____in for, and consent to, treatment, or to receive medical advice over the phone if they are taking care of my child in my absence. I understand telephone triage and advice services regarding direct patient care will be extended to the above persons only when the child is in their care. This does not allow them to have access to confidential health information that is not relevant for that particular visit. In the event of an emergency or other illness, I understand that the physicians and staff of Westbrook Medical Center will deliver any medical care deemed necessary regardless of the accompanying adult.

1) Name:_____

Relationship to patient:_____ Phone #:_____

2) Name:_____

Relationship to patient:_____ Phone #:_____

3) Name:_____

Relationship to patient:_____ Phone #:_____

If a document is to be picked up by a non-legal guardian, Westbrook must have written consent from the legal guardian. This authorization serves as consent for any medical treatment Westbrook deems medically necessary and appropriate. This will remain in effect until revoked by written consent.

_____ _____

Legal guardian signature Print Name

Date _____ _____

Relationship to patient

COMPLETE THIS SECTION, IF APPLICABLE, IF PATIENT IS 18 OR OLDER:

I _____ Birthdate_____authorize the following people to have access to my treatment information and appointment dates. This will remain in effect until revoked by written consent.

1) Name:_____

Relationship to patient _____Phone #_____

2) Name:_____

Relationship to patient _____Phone # _____