Today's Date:_____/_____/

Name:____Soc Sec #:_______-_______-_______Birth Date:______/______/_______

Race:______________________Sex/Gender:______________________Sexual Orientation:___________________________________

Employer:__________________ Marital Status:______________________Children/Ages:____________________________________

How did you hear about us?____

Home phone#:_________________Ok to leave message?______Cell phone #:_________________Ok to leave voicemail?___________

Ok to sent text message?__________Email:____Ok to send email?_____________

Address:____ City:__________________ State:_________ Zip:____________________

Emergency Contact Name and phone number:____

Insurance Carrier & State Issued By:_________________________________Subscriber ID:___________________________

Group #:________________Subscriber Name & relationship to you:______________________________Date Issued:______/______/_______

Medical History

Current medications:____

Drug allergies:____

Prior hospitalizations:____

Illnesses or Surgeries::____

Primary physician and contact information:____

Are you pregnant? □ YES □ NO If so, how many months?________ Who is your doctor?___________________________________

Do you smoke? □ YES □ NO If so, how many per day? ________

Mark if you have had any of the following:

- □ Neurological problems
- □ Cardiovascular problems
- □ Respiratory problems
- □ Musculoskeletal problems
- □ Gastrointestinal problems
- □ Genitourinary problems
- □ Vascular problems
- □ Ear/Nose or Throat problems
- □ Endocrine problems
- □ Alcohol or drug problems
- □ Other__________________

Family history of substance abuse, medical, or psychiatric conditions:____

____

Print Client Name:____________________________Client Signature:______________________________Date:__________

Counselor/Psychiatrist Signature:____Date:__________

Signature of Parent/Guardian if Client is a Minor:____Date:__________

Professional Disclosure Statement

Information for Clients, Informed Consent and Agreement
Mental Health/Substance Abuse Treatment Services
25 Orange Street, Asheville, NC 28801 | Phone: 828-772-6715 | Fax: 828-378-0223

Welcome to Willow Wellness and Recovery! We believe in the resilience of the human spirit and that change is possible. Fueled by the desire to offer quality, relationship-based care, we offer an innovative, comprehensive opioid dependence treatment program consisting of medication and psychotherapy services. We look forward to working with you!

Provider Qualifications:
Dr. Csapo received her Doctor of Medicine degree in 2002 from Dartmouth Medical School in Hanover, NH. She completed a general psychiatry residency at the University of New Mexico in Albuquerque, NM in 2006 and has been a certified Suboxone provider since 2004. Dr. Csapo is board certified with the American Board of Psychiatry and Neurology and the American Board of Addiction Medicine. She is a member of the American Psychiatric Association and the North Carolina Medical Society.

Kim Skelton received her Bachelor of Arts degree in Psychology in 2003 and her Master of Arts degree in Community Counseling in 2005 from the University of Alabama. In addition, she completed a post-master's addiction certificate program in 2009. In North Carolina, she is board certified as a Licensed Professional Counselor Supervisor and a Licensed Clinical Addiction Specialist. She is a member of the American Counseling Association and the Association for Creativity in Counseling.

Suboxone Program: Willow Wellness and Recovery prides itself on providing highly individualized, comprehensive care. Unlike larger clinics, we know each of our clients by name and are able to offer a wider variety of accessible psychotherapy services. Support is vital in building a sustainable recovery lifestyle. Med-assisted treatment is a tool to aid you in developing a better life. Our program includes individualized, comprehensive treatment utilizing a combination of psychiatry and psychotherapy.

Program Expectations: 1) meet with the psychiatrist monthly; 2) attend a minimum of **two** groups per month for the length of time you are in the program; 3) regular, random drug screens. While these are minimum requirements, you are invited and encouraged to attend more frequently. We highly recommend that you seek out local recovery resources such as 12-Step meetings (NA, AA), Celebrate Recovery, SMART Recovery, Refuge Recovery, Women for Sobriety, etc. Other treatment modalities such as yoga, acupuncture, nutritional counseling can also be helpful.

Fees & Length of Service: It is important that you are informed and aware of all financial responsibilities, as outlined below.

Buprenorphine Program Bundled Service..$325 per month
This fee includes monthly meetings with Ilona Csapo, MD for med management, group therapy, ongoing case management, and regular, random drug screens. We utilize "Point of Care" testing UDS cups in the office. Best practice care includes periodic confirmation at the lab. We partner with Mako Laboratory to conduct confirmations. UDS cups are sent to confirm buprenorphine for each patient approximately 2-3x per year. Confirmations are also requested if a patient wants to dispute an aberrant screen. If you are insured, the lab will bill your insurance for UDS confirmation. Otherwise, you are responsible for the cost of confirmations conducted by the lab.

Initial payment is due at the time of the first appointment and at each subsequent, monthly follow-up medication management appointment. Forms of payment accepted are cash and credit card. We do not accept checks. When using a credit card the following surcharges apply: $10 for buprenorphine program.

Insurance Coverage: The Buprenorphine Program is operated on a fee-for-service basis. Patients with health insurance are provided receipts to file with their specific plans and are often reimbursed a significant portion of the cost. We are not able to tell you what your plan covers. Please contact your insurance carrier for information about **out-of-network** benefits for outpatient mental health or addiction treatment. For info on obtaining coverage through the Affordable Care Act visit www.healthcare.gov.

Use of Diagnosis: Most insurance carriers require a diagnosis of a mental health or substance use condition and before they will agree to reimburse you. If a qualifying diagnosis is appropriate in your case, we will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made becomes part of your permanent insurance records.

Confidentiality: Pursuant to HIPAA and Federal Law 42 CFR, all of our communication becomes part of the clinical record, which is accessible to you upon request. We will keep confidential anything you say as part of our treatment relationship, with the following exceptions: (a) you direct us in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) any one of us is ordered by a court to disclose information.

Client Rights: HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your record be amended; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints made about policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. All providers in this practice use one Electronic Medical Records System for all patient visits in private or corporation practices.

Right to Refuse Service and/or Refer: We reserve the right to refuse service and/or offer referral options if it is determined this practice may not best serve patient needs. This may be based on safety concerns, patient presenting as hostile, disruptive or intoxicated/high, need to protect an established patient's privacy, ability to pay or non-compliance with treatment contract, etc.

Scheduling and Hours: Appointments are scheduled in advance & require 24 hrs notice of cancellation. After the first missed appointment, clients will be billed at the full rate. The office is closed on Sunday & Monday. Please refer to group therapy schedule for current offerings.

After Hours Support and Emergencies: This practice does not provide emergency services. If you are in need of emergency services, you have the following options: 1) Go to the closest ER or call 911; 2) Contact Mobile Crisis at 1-888-573-1006 for 24/7/365 Crisis Response; or 3) Contact Vaya Health at 1-800-849-6127 at any time. We provide all clients in advance our away-from-office dates. We check voicemails daily Monday-Friday and return calls within 24-48 hours.

Complaints: Although clients are encouraged to discuss any treatment concerns with us, you may file a complaint with the relevant licensing board should you feel your provider has been in violation of provider's code of ethics.
North Carolina Medical Board | PO Box 20007, Raleigh, NC, 27619-0007 | 919-326-1100 or 919-326-1109
North Carolina Board of Licensed Professional Counselors | PO Box 1369, Garner, NC 27529 | 919-661-0820

Acceptance of Terms: We agree to these terms and will abide by these guidelines.

Print Client Name:____

Client Signature:____Date:__________

Counselor/Psychiatrist Signature:____Date:__________

Signature of Parent/Guardian if Client is a Minor:_____________________________Date:__________

25 Orange Street, Asheville, NC 28801

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect January 1, 2013 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between providers and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

Treatment refers to activities in which we provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychotherapy session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when we obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of this practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities this office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. **Disclosures** refer to activities you authorize which occur outside this office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. This office may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want this office to send any of your protected health information of any sort to anyone outside this office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might by your request that we talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before this office talks to that teacher, you will have first signed the proper authorization for us to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: psychotherapy notes. In recognition of the importance of the confidentiality of conversations between providers-clients in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate form the overall "designated medical record."

Insurance companies cannot secure "Psychotherapy notes" nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record."

"Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information

about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payers of care, such as Medicare and Workers Compensation, require the release of both your progress notes and psychotherapy notes in order to pay for your care. If this office is forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes. Most of the time we will be able to limit reviews of your protected health information to only your “designated record set” which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of you care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your “designated mental health record.”

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that this office train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as “Business Associates.” We do employ business associates to assist with administrative matters and these “Business Associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out “Duty to Warn” Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

We never release any information of any sort for marketing purposes.

V. Client’s Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which this office may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so this office will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in the designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although this office may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from this office, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. We am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. We reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). Our duties as health care providers on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and our privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let us know and we will get you a copy of these documents we keep on file for auditing purposes.

VI. Complaints

I am the appointed “Privacy Officer” for my practice per HIPAA regulations. If you have any concerns of any sort that this office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don’t have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

Willow Wellness and Recovery, PC
Privacy Officers

I, ____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

____ ______________________
Client or Parent Signature (if client is a minor) Date

____ ______________________
Provider Date

Suboxone Medication Education

Suboxone® (a film containing buprenorphine and naloxone) is an FDA approved medication for treatment of people with heroin or other opioid addiction.

If you are dependent on opiates – any opiates - you should be in as much withdrawal as possible when you take the first dose of buprenorphine. It you are not in withdrawal, buprenorphine can cause severe opiate withdrawal. For that reason, you should take the first dose in the office and remain in the office for at least 2 hours. We recommend that you arrange not to drive after your first dose, because some patients get drowsy until the correct dose is determined for them.

Some patients find that it takes several days to get used to the transition from the opiate they had been using to buprenorphine. During that time, any use of other opiates may cause an increase in symptoms. After you become stabilized on buprenorphine, it is expected that other opiates will have less effect. Attempts to override the buprenorphine by taking more opiates could result in an opiate overdose. You should not take any other medication without discussing it with the physician first.

Combining buprenorphine with alcohol or other sedating medications is dangerous. The combination of buprenorphine with benzodiazepines (such as Valium®, Librium®, Ativan®, Xanax®, Klonopin®, etc.) has resulted in deaths.

The form of buprenorphine (Suboxone®) you will be taking is a combination of buprenorphine with a shortacting opiate blocker (Naloxone). It will maintain physical dependence, and if you discontinue it suddenly, you will likely experience withdrawal. If you are not already dependent, you should not take buprenorphine, it could eventually cause physical dependence.

Most patients end up at a daily dose of 12 to 16 mg of buprenorphine. Beyond that dose, the effects of buprenorphine plateau, so there may not be any more benefit to increase in dose. It may take several weeks to determine just the right dose for you. The first dose is usually 2-4mg.

If you are transferring to Suboxone® from methadone maintenance, your dose has to be tapered until you have been below 30mg for at least a week. There must be at least 24 hours (preferably longer) between the time you take your last methadone dose and the time you are given your first dose of buprenorphine. Your doctor will examine you for clear signs of withdrawal, and you will not be given buprenorphine until you are in withdrawal.

Side effects May Include: Respiratory problems. You have a higher risk of death and coma if you take SUBOXONE with other medicines, such as benzodiazepines or alcohol, Dependency or abuse, Liver problems, Allergic reaction, Opioid withdrawal, Decrease in blood pressure, Nausea, Vomiting, Headache, Sweating, Numb or sore mouth, Constipation, Painful tongue, Intoxication (feeling lightheaded or drunk), Irregular heart beat, Blurred vision, Back pain, Fainting, Dizziness, Sleepiness, Insomnia

I have read and understand these details about buprenorphine treatment. I wish to be treated with buprenorphine.

Patient Signature: ____ Date______________

Provider Signature: ____Date_______________

Buprenorphine Program Expectations and Contract

Please initial that you have carefully read and understand the following program expectations.

Medication Management & Drug Screens

1. Opioid replacement therapy can be a helpful tool in developing a recovery lifestyle. Research shows it can take approximately six months to one year of buprenorphine maintenance for habits to change and for the brain to recover. Working in conjunction with my providers I understand that I will begin tapering at an agreed upon time until successfully tapered. ____

2. I will only take buprenorphine as prescribed by Ilona Csapo, MD. I will not take more medication than prescribed. I will not share or sell my Suboxone. I understand that if my drug screen is negative for buprenorphine, I will be immediately dismissed from the program. **<u>We have zero tolerance for medication being diverted</u>**. ____

3. I understand that I may be required to bring my medication bottle/box (including used film sleeves) to each successive appointment with Dr. Csapo for a medication count. ____

4. I understand and consent to verbal and written communication for coordination of care between program staff and with the specified lab and pharmacy. ____

5. I understand that the entire quantity must be filled each month and that **<u>there will be no partial or early fills</u>**. ____

6. I understand that prescription replacements will **<u>NOT</u>** be provided because of loss or theft. We highly recommend storing medication in a lockbox and away from children and out of high temperatures. ____

7. I understand that Dr. Csapo checks the NC Controlled Substances Database on a regular basis. If it is found that any other physician is concurrently prescribing opioids, stimulants (such as Adderall, Ritalin, Vyvanse), or benzodiazepines (such as Xanax, Klonopin, Valium), I understand that this is grounds for immediate dismissal from the program. ____

8. I understand that random drug screens will be required and are expected to be free of any substances except those prescribed. I understand I must present within **<u>24 hours</u>** of notification for a random drug screen if requested by program. A drug screen that is positive for illegal or non-prescribed substances or one that has been adulterated may be grounds for immediate dismissal from the program. I understand I can request lab confirmation at my cost if I feel my test is falsely positive. ____

Program Policies

1. I will attend my scheduled appointments with Dr. Csapo and **<u>a minimum of two group therapy sessions per month</u>** per program requirements. I also understand that my treatment plan may be changed to include increased program contact (more groups/drug screens/individual therapy) if I am non-compliant with program expectations. If I do not attend, I understand I will receive 1) a verbal warning, then 2) a treatment

contract. If noncompliance continues, I will receive a rapid taper and be discharged from the program. ____

2. I understand that program office hours are Tuesday – Friday from 10am-5pm. All appointment scheduling and medication refills are handled during open-business hours. ____

3. I understand that all medication refills are called in at the end of the business day. If you will need a medication refill, please call a minimum of 2-3 days in advance to allow time for Willow and pharmacy staff to have adequate time to coordinate refill. ____

4. Please be advised that **our program does not provide emergency services**. If you have an emergency, please call the closest ER. You may also call the **North Carolina Mobile Crisis Management at 1-888-573-1006** at any time. ____

5. If you will be undergoing a procedure on an outpatient basis involving opioid pain medications, it is your responsibility to coordinate with this program and other providers in advance concerning procedure. ____

6. If you have private insurance (through an employer or private pay), you may request an invoice to submit to your insurance company to file for out-of-network benefits. It is the patient's responsibility to request an invoice at the time of his or her appointment with the provider. Invoices are sent out monthly. Invoices are not provided for patients with Medicaid or Medicare plans. I am aware that requests for more than one month of invoices will require additional time to process. ____

7. I am aware that if I need to change or cancel my appointment, that I am required to do so at least 24 hours in advance. Same day cancellations or no shows will result in additional fee of $25. **Multiple late cancellations or no shows may result in dismissal from program**. ____

8. I understand that, though, Willow Wellness staff will work in conjunction to provide me with the information, skills, and resources to facilitate me in my recovery, I am required to have read and understood the aforementioned program policies. I understand that, ultimately, **my recovery is my responsibility**. I am aware that I am required to keep a copy of this form for my records. Should I have any questions this contract or my treatment, I can contact treatment team for more information.

9. I am able to comply with the terms of the financial agreement. ____

By reading and initialing each of the above items and signing below, I understand that I have entered into a contract with my treatment providers. I understand that a violation of any of the above terms is grounds for discontinuation of buprenorphine and referral to a higher level of care. I understand that I may be refused service and/or referred if it is determined I would be better served elsewhere.

Patient Name (print): ____

Patient Signature: ____ Date: ______________

Provider Signature: ____ Date: ______________

Authorization for Release of Protected Health Information

Patient Name:_____________________________________ DOB:______ /______/_______ SSN: _______-_______-_______

Person or Facility to Disclose/Receive to or from: ____

Address:____

Phone Number:_______________________________ Fax Number:________________________________

I am either the person named above or someone who can legally act for the person. I hereby authorize staff of Willow Wellness and Recovery, PC to disclose to, receive from and communicate with the following person or facility in written, verbal and/or electronic format:

INFORMATION THAT MAY BE RELEASED/SHARED:

____**Complete Health Record** which may include demographic information, reason for referral, alcohol/drug and legal history, urinalysis and breathalyzer results, psychiatric evaluations, medication records, progress notes, attendance and progress in treatment, assessment results or diagnoses, service or treatment plan, discharge information) including information about communicable diseases such as HIV or other sexually transmitted diseases

OR

____**My health information about the following treatment or condition:** ____

Please check ONE: My health information for ____**ALL DATES** or ______**ONLY THE FOLOWING DATES:** _______________________

Reason:___Provide continuity of care ___Compliance with program ___Personal Use ___Legal Purposes
___Social security/disability ___Insurance/Managed care ___Other___________________________________

- If I elect to use insurance, I understand that staff will communicate with my insurance company to provide information needed for me to utilize my insurance benefits.
- I understand that Willow Wellness and Recovery, PC staff coordinate care with designated pharmacy and lab.
- I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
- I understand that I may revoke this authorization at any time by notifying my treatment provider in writing, but if I do, it will not have any effect on any actions providers took before it received the revocation. Otherwise, this release of information is valid for one year from the signed date.

Patient Signature:____ **Date**:______ /______/_______

If you are not the patient, please state your authority to act for the patient:____

Staff Signature:____**Date:**______ /______/_______

Date this authorization was revoked, if applicable:______ /______/_______