

GARFIELD COUNTY HOSPITAL DISTRICT CONTROLLED SUBSTANCE CONSENT (attachment A)

***Prescriptions are not given without the completion of this document**

PATIENT IDENTIFICATION:			
NAME:		DOB:	
ADDRESS:	CITY:	STATE:	ZIP CODE:
TELEPHONE NUMBER (include area code):		OTHER INFORMATION:	
CONSENT:			
<p>I consent to the use of confidential information about me to plan, provide and coordinate treatment and benefits for me, or for other purposes authorized by law. I further grant permission to disclose my confidential information to the identified entities listed below. Information may be shared verbally, computer data transfer, mail or fax.</p> <p><u>Check all below who are included in this consent and identify them by name and address:</u></p> <p><input type="checkbox"/> Health Care Providers:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Mental Health Providers:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Chemical dependency providers:</p> <p>_____</p> <p>_____</p> <p><input type="checkbox"/> Other:</p> <p>_____</p> <p>_____</p>			
I authorize and consent to sharing the following records and information (check all that apply):			
<input type="checkbox"/> Health care information		<input type="checkbox"/> Treatment or care plans	<input type="checkbox"/> Family, social & employment history
NOTE: If your health care records any of the following information, you must also complete this section to include these records.			
I consent to disclose the following records (check all that apply):			
<input type="checkbox"/> Mental Health		<input type="checkbox"/> HIV/AIDS/STD test results, diagnosis, treatment	<input type="checkbox"/> Chemical Dependency treatment
This consent is valid for one year or until _____.			
I may revoke or withdraw this consent at any time in writing, but the revocation will not affect any information already released.			
A copy of this form is valid to give my permission to share records.			
SIGNATURE		DATE	WITNESS SIGNATURE
PARENT-REPRESENTATIVE SIGNATURE (IF APPLICABLE)		TELEPHONE NUMBER (include area code)	DATE
I am authorized to sign since I am the: (attach proof of authority)			
<input type="checkbox"/> Parent		<input type="checkbox"/> Legal Guardian (attach court order)	<input type="checkbox"/> Personal representative
<input type="checkbox"/> Other:			
<p>NOTICE TO RECIPIENTS OF INFORMATION: If these records contain information regarding HIV, AIDS, or STDs you may not further disclose the information without the patient's specific permission. If you have received information related to drug or alcohol abuse by the patient you must include the following statement when further disclosing information as required by 42 CFR 2.32:</p> <p>"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR). Federal rules prohibit you from making further disclosure of this information unless disclosure is expressly permitted with the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."</p>			