Intensive Health
a stepworks company

Patient Registration Form

Name: _____ Today's Date: _____ / _____ / _____

Social Security Number: _____ _____ _____ Date of Birth: _____ / _____ / _____

_____ _____ _____ _____
Street City State Zip Code

Phone: (_____) _____ - _____ Other Phone: (_____) _____ - _____

Email: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other

Gender: ☐ male ☐ female ☐ other

Pronouns: ☐ he/him ☐ she/her ☐ them/they

Marital Status: ☐ single ☐ married ☐ separated ☐ divorced ☐ widowed

Ethnicity: ☐ asian ☐ black ☐ hispanic ☐ white ☐ North American native ☐ other ☐ unknown

Authorization to Release Information

I hereby authorize telephonic/electronic release of medical information to the following person(s):

Full Name: _____ ☐ spouse ☐ parent ☐ child ☐ other

☐ appointment ☐ medical ☐ psych Patient initials: _____

Full Name: _____ ☐ spouse ☐ parent ☐ child ☐ other

☐ appointment ☐ medical ☐ psych Patient initials: _____

Power of Attorney

Do you have a medical power of attorney, living will, or advance directive? ☐ yes ☐ no ☐ I don't know.
If you have one of the above, please bring a copy for your records. If you have questions about this, ask your provider during your visit.

Emergency Contact

Name: _____ Phone: (_____) _____ - _____ Relationship: _____

Primary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ _____ _____

Relationship: ☐ spouse ☐ parent ☐ child ☐ other

Secondary Insurance

Insurance Name: _____

Member ID: _____

Group Number: _____

Date of Birth: _____ / _____ / _____

Social Security Number: _____ _____ _____

Relationship: ☐ spouse ☐ parent ☐ child ☐ other

I authorize the **release of any medical information** necessary to process all insurance claims. Further, I release **payment of medical benefits** to Stepworks Recovery Centers LLC.

I understand that I am fully responsible for **payment at the time of service** and any unpaid account balances including but not limited to, co-payments, co-insurance, and deductibles not paid by my insurance carrier. Accounts not paid in full within 30 days may be subject to a finance charge of up to 18% annually. In addition, should my account become delinquent and referred to a collection agency, I understand that I will be responsible for the balance owed on the account plus all costs incurred in collecting the balance.

_____ _____ _____ / _____ / _____

Patient Signature or Legal Representative Relationship to Patient Date

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Consent to Treat

Patient Name: _____ Date of Birth: _____ / _____ / _____

I give consent to authorized team members at Stepworks Intensive Health ("Intensive Health") to provide assessment, evaluation, treatment, services, and psychotherapy to me (or my dependent) including services provided via telemedicine. I understand the following:

- the importance of attending all scheduled appointments
  - Failure to attend may disrupt medication refills, cause delays in care, or result in my discharge from the practice.
- I may contact Intensive Health for re-evaluation at any time
- my responsibility for my personal safety (explained in the treatment agreement)
- the benefits and risks of psychotherapy and medication
  - Psychotherapy may elicit uncomfortable thoughts, feelings, and troubling memories.
  - Medications may have unwanted side effects.
- my responsibility to tell my provider about any unexpected or unwanted side effects

Telemedicine Consent

I consent to receive treatment services via telemedicine. I understand the following:

- It is my responsibility to maintain adequate phone/computer/internet connectivity.
- There are inherent privacy and security risks associated with telemedicine and online data.
- I may withdraw my consent at any time without losing my right to future treatment.
- My healthcare provider may decide a traditional face-to-face encounter is more appropriate.
  - The provider may stop the telemedicine visit at any time and schedule a face-to-face visit.
  - Technical difficulties may also necessitate an in-person visit.
- While I may expect to benefit from telemedicine services, positive results cannot be guaranteed.
- Medical privacy/confidentiality laws also apply to telemedicine.
- I am responsible for insurance copayments, coinsurance, and deductible amounts for telemedicine services.
- If my appointment ends prematurely, I must contact Intensive Health (270)765-5900 immediately to reschedule.

Release of Liability

- Intensive Health is not responsible for lost or stolen items.
- I am responsible for my own personal safety. While Intensive Health strives to provide a safe environment, my decisions and behaviors affect my safety and sobriety.
- I hereby release, waive, and discharge from, and covenant not to sue Stepworks Recovery Centers, LLC (dba Intensive Health), its officers, servants, agents, and employees (hereinafter referred to as releases) on account of any and all liability, claims, demands, actions, and causes of action whatsoever arising out of or relating to any loss, damage, or injury, including death, that may be sustained by me, or to any property belonging to me, whether caused by the negligence of the releases or otherwise, while I am a patient at Intensive Health, or while in, on, or upon the premises where treatment is being conducted, while in transit to or from the premises, or in any place or places connected with Intensive Health.
- It is my express intent that this release shall bind the members of my family and spouse if I am alive, and my heirs, assigns, and personal representative if I am deceased, and shall be deemed as a release, waiver, discharge, and covenant to not sue the above-named releases.

Consent to Video Surveillance and Recording

I understand that Intensive Health uses video surveillance and recording of the following:

- waiting room and front desk area
- nurses station
- most public areas
- group therapy areas

This technology supports the security of our facility, the integrity of our programs, and our quality improvement efforts. Video recordings are stored at the sole discretion of Intensive Health. They are not a part of your health record and will not be released as part of any records release. In the event of alleged rule-breaking, video recordings may be used to assess actions and potential consequences. These video recordings will not be sold, distributed, displayed, or used for any unlawful purpose. **By signing this document and consenting to the items herein, I hereby specifically acknowledge and approve the use of video surveillance and recording and release any personal rights to these recordings.**

Non-Discrimination Policy

Intensive Health serves all patients regardless of inability to pay. We pledge to serve all patients; offer discounted fees for patients who qualify (based on family size and income); not deny services based on race, color, sex, age, national origin, disability, religion, gender identity, sexual orientation, or inability to pay; and to accept insurance, including Medicaid and Medicare.

Patient or Legal Guardian Signature: _____

Date: _____ / _____ / _____ Time: _____ : _____ ☐ A. M. ☐ P. M.

Intensive Health
a stepworks company

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO), and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Confidentiality of Alcohol and Drug Abuse Records

The confidentiality of alcohol and drug abuse patient records maintained by us is protected by Federal law and regulations. Generally, we may not say to a person outside the treatment center that you are a patient of the treatment center, or disclose any information identifying you as an alcohol or drug abuser unless:

1. You consent in writing (as discussed below in “Authorization to Use or Disclose PHI”);
2. The disclosure is allowed by a court order (as discussed below in “Uses and Disclosures”); or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation (as discussed below in “Uses and Disclosures”).

Violation of the Federal law and regulations by the treatment center is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by you either at the treatment center or against any person who works for the treatment center or about any threat to commit such a crime (as discussed below in “Uses and Disclosures”).

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or local authorities (as discussed below in “Uses and Disclosures”).

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law (public health issues as required by law, communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, Workers' Compensation, inmates). Required uses and disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object, unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

- You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health

information that is subject to law that prohibits access to protected health information.

- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
- Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another health care professional.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (e.g. electronically).
- You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

Terms

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published 04/01/2015 and becomes effective from the date of signature to 365 days forward.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Your signature below acknowledges that you have received this Notice of our Privacy Practices:

Patient Signature: _____

Patient Printed Name: _____

Date of Birth: _____ / _____ / _____

Date: _____ / _____ / _____

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Health History Questionnaire

Patient Name: _____ Date of Birth: _____ / _____ / _____

Date: _____ / _____ / _____

Reason for Visit: _____

_____

_____

Preferred Pronouns: ☐ she/her ☐ he/him ☐ they/them ☐ other: _____

Medical History:

☐ heart disease
☐ lung disease
☐ infections (hepatitis, endocarditis, etc.)
☐ heart attack
☐ thyroid disease
☐ genetic disease
☐ blood disease, clotting
☐ stroke
☐ diabetes
☐ neurological problems
☐ stomach problems
☐ seizures
☐ kidney disease
☐ bone or joint problems
☐ ectopic pregnancies
☐ cirrhosis
☐ other: _____

_____

Surgical History: _____

_____

Allergies: _____

_____

Mental Health History: ☐ depression ☐ anxiety ☐ bipolar ☐ schizophrenia ☐ personality disorder

other: _____

Family Medical History: ☐ heart disease ☐ diabetes ☐ cancer ☐ substance use ☐ mental health

Preventative Care History:

☐ flu vaccine	Date: _____ / _____ / _____	☐ PAP smear	Date: _____ / _____ / _____
☐ COVID vaccine	Date: _____ / _____ / _____	☐ prostate exam	Date: _____ / _____ / _____
☐ hepatitis B vaccine	Date: _____ / _____ / _____	☐ STD testing	Date: _____ / _____ / _____
☐ physical exam	Date: _____ / _____ / _____	☐ HIV test	Date: _____ / _____ / _____
☐ colonoscopy	Date: _____ / _____ / _____	☐ hepatitis C test	Date: _____ / _____ / _____
☐ TB skin test	Date: _____ / _____ / _____	☐ hepatitis B test	Date: _____ / _____ / _____
☐ mammogram	Date: _____ / _____ / _____		

List of Other Current Healthcare Providers: _____

_____

Substance Use History: _____

_____

In the past two years, I have used:

☐ heroin or other opioid
☐ cocaine
☐ alcohol
☐ methamphetamine
☐ marijuana
☐ benzodiazepines or sedatives
☐ hallucinogens (LSD, mushrooms, PCP, ecstasy)
☐ other: _____

_____

I have used drugs:

☐ IV ☐ oral ☐ smoking ☐ nasal ☐ other: _____

Treatment History:

☐ counselor (☐ in the past ☐ currently)
☐ case manager (☐ in the past ☐ currently)
☐ IOP
☐ attend support group meetings (☐ in the past ☐ currently)
☐ live in sober living (☐ in the past ☐ currently)

Legal History:

☐ legal issues (☐ in the past ☐ currently)
☐ CPS case (☐ in the past ☐ currently)
☐ incarcerated due to substance use (☐ in the past ☐ currently)
☐ probation/parole
☐ other: _____

Social History:

- ☐ in a relationship
- ☐ children (☐ in the home ☐ not in the home)
- ☐ homeless in the past two years
- ☐ experienced trauma/abuse
- ☐ high school diploma
- ☐ difficulty reading
- ☐ employed (☐ full-time ☐ part-time)
- ☐ tobacco use
  - ☐ cigarettes ☐ vape ☐ chew ☐ snuff

Do you have trouble accessing... ☐ food ☐ housing ☐ transportation ☐ clothes ☐ employment

Patient Name: _____

Signature: _____

Date: _____ / _____ / _____

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Sexual Health Questionnaire

Patient Name: _____ DOB: ____ /____ /_____ Date: ____ /____ /_____

Part 1 - Preliminary Screening

These questions help us determine your risk of sexually transmitted infections (STIs), including viral hepatitis. If you answer "yes" to anything in Part 1, you will also need to complete Part 2. **Please answer honestly.**

Have you ever had unprotected sex (sex without a condom)?
- ☐ yes
- ☐ no

Have you had multiple sexual partners in the last year?
- ☐ yes
- ☐ no

Have you ever shared needles or syringes (for drugs, tattoos, or any other reason)?
- ☐ yes
- ☐ no

Have you ever had a sexual partner who has been diagnosed with an STI or viral hepatitis?
- ☐ yes
- ☐ no

Have you ever exchanged sex for money, drugs, or other goods/services?
- ☐ yes
- ☐ no

Have you ever had a blood transfusion or received blood products before the year 1992?
- ☐ yes
- ☐ no

Have you ever been diagnosed with an STI in the past?
- ☐ yes
- ☐ no

If you answered "yes" to anything above, proceed to Part 2.
If all of your answers were "no," your screening is complete.

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Patient Name: _____ DOB: ____ /____ /_____ Date: ____ /____ /_____

Part 2: Detailed Screening

This section helps us gather more specific information about your potential risk factors.

How many sexual partners have you had in the last six months?

- ☐ 1-2
- ☐ 3-5
- ☐ 6 or more

Do you know the STI status of your current or recent sexual partners?

- ☐ yes
- ☐ no
- ☐ not sure

Have you ever been vaccinated for hepatitis B?

- ☐ yes
- ☐ no
- ☐ not sure

Have you ever been tested for hepatitis C?

- ☐ yes
- ☐ no
- ☐ not sure

In the past year, have you noticed any unusual symptoms (like sores, itching, or unusual discharge) in your genital area?

- ☐ yes
- ☐ no
- ☐ not sure

Do any of your close family members have a history of viral hepatitis?

- ☐ yes
- ☐ no
- ☐ not sure

If you answered “yes” or “not sure” to anything above, your provider will discuss whether more information or further actions are necessary.

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MAT Treatment Plan

- The patient will adhere to drug screening at office visits and randomly when requested for adherence monitoring.
- The patient will consent to random drug screens and pill counts at least twice per year.
- KASPER reports will be evaluated at least once every other three months.
- Assuming appropriate urine drug screens and adherence to counseling, medication plan, and a clean lifestyle free from substance use and addictive behaviors, the treatment plan will proceed as follows:
    - initial visit
    - weekly office visits until approved by provider
    - when appropriate, the patient advances to monthly visits
    - medication refills or injections are only given at scheduled appointment times
- If the patient fails a urine drug screen or is unable to adhere to the treatment plan, office visits may revert back to once weekly or more frequently. (The patient and provider may also agree to increase the frequency of office visits for other reasons.)
- If the patient is receiving long-acting injectables, or if it is decided between the patient and provider, office visit frequency may be altered as necessary for best patient care.

Patient Name: _____

Date of Birth: _____ / _____ / _____

Patient Signature: _____

Date: _____ / _____ / _____

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Treatment Agreement

Patient Name: _____

Date of Birth: _____ / _____ / _____

Please **initial each line below** to indicate that you agree with the statement. Violating the terms below could result in changes to your treatment plan or discharge from the practice.

1. _____ I will arrive on time to all of my scheduled appointments. (If I am not on time, I may not be seen.) I will cancel at least 24 hours before my appointment time if unable to attend. If I miss an appointment, I know I will not receive my medications until I am seen for an office visit.
2. _____ I will conduct myself courteously and respectfully to Stepworks team members and other patients.
3. _____ I will pay all fees including copays and deductibles at the time of my appointment.
4. _____ I will not arrive at the office intoxicated or under the influence of any drugs.
5. _____ I will not share, sell, or give away any medications I receive from this office.
6. _____ I know that using opiates while receiving MAT treatment could result in severe withdrawal symptoms and increase my risk of overdose. I also know that abruptly stopping MAT treatment could result in withdrawal.
7. _____ I know that lost or stolen medications will not be replaced or refilled early. I will keep my medications safe and secure.
8. _____ I will inform my Intensive Health providers of any medication changes made by other providers I may see.
9. _____ I will inform all of my other providers (and anyone who provides care to me) of my treatment with Intensive Health.
10. _____ I will actively participate in my treatment plan including counseling, group therapy, or treatment programs.
11. _____ I know my treatment will be monitored via KASPER reports, communications with other people involved in my care, and drug screens (random and scheduled).

Patient Signature: _____ Date: _____ / _____ / _____

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Controlled Substance Contract

Patient Name: _____ Date of Birth: _____ / _____ / _____

I agree to abide by the following guidelines for managing my prescriptions from Intensive Health. Intensive Health includes the following providers: Thomas Ingram MD, Gregory Smith MD, Joyce Johnson APRN, Jen Cothern APRN, and Kimberly Gambino, APRN.

I understand that I am only to receive controlled substances from these providers unless discussed beforehand.

I agree to inform any other providers (to include any specialists, dentists, etc.) involved in my care of my agreement with Intensive Health. If another provider wishes to suggest changes in my treatment plan involving controlled substances, they can contact Intensive Health during regular business hours. However, no changes will be made without the other provider contacting this office.

I understand that if my medicines are lost or stolen, they will not be refilled prior to the next refill date. I will not request refills prior to the refill date. If I use up my supply of medication before the date of the next refill, I understand that my provider will not provide extra medication. Further, I understand that I may suffer withdrawal symptoms if I run out of my medication early. If I have difficulty taking the medication as prescribed I will discuss this with my provider at a scheduled office visit.

I understand that my provider may require monitored or unmonitored drug screenings and pill counts as part of my controlled substance contract. I may be required to do random drug screens. If asked to complete a random drug screen, I understand that these must be completed within 24 hours of the request or by the time line indicated by the provider. If I fail these drug screenings at any time during my treatment with Intensive Health, the provider has the right to discontinue prescribing controlled substances for me. I understand that when I am asked to provide a drug screen I am unable to leave the office for any reason and if I leave the office that my drug screen will be considered as failed. I understand that, if I am called for a random drug screen and do not attend, I will be required to see the counselor and revert to more frequent visits.

Initial the following:

_____ I agree not to abuse alcohol or other illicit drugs.

_____ I will not sell or share controlled substance medications. I will not take more medication than is prescribed.

_____ I will use the following pharmacy to fill all of my controlled substance prescriptions:

Pharmacy: _____

If I violate the terms of this contract, I understand that the providers at Intensive Health may no longer prescribe controlled substance medications for me. If this occurs, I understand that I may receive my care elsewhere. I may also continue with my current provider, but I will not receive controlled substance medications from Intensive Health. If I change providers, I agree to allow my current provider to contact my new provider to transfer medical information, including information about my controlled substance prescriptions.

Patient Signature: _____ Date: _____ / _____ / _____

Provider Signature: _____ Date: _____ / _____ / _____

Witness Signature: _____ Date: _____ / _____ / _____

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Welcome to Intensive Health's PSS Program

Dear Intensive Health patient,

Intensive Health has launched an exciting new Peer Support program. Each patient receiving buprenorphine (Suboxone, Subutex, Zubsolv, Sublocade) will be assigned a peer support specialist (PSS) to help you on your recovery journey. This will meet the requirement for a behavioral modification program outlined in Kentucky state regulations. Counseling is still available for patients who need it and is recommended but no longer required. Your PSS will be able to meet with you in office at the same time as your provider visits and can also follow up and be a contact point for you when you aren't in the office, if you are struggling or need some assistance, or just need a touch point to check in. Patients who have a longer period of sobriety (one year or greater) will only be expected to interact with a PSS monthly.

In addition to outlining behavioral modification programs for buprenorphine patients, Kentucky regulations and guidelines also address random pill counts and drug screens for patients receiving any controlled substance from this office. These drug screens are generally witnessed and must be accompanied by a pill count in the office. Unfortunately, emailing a picture of your pills does not meet this requirement. While we were able to call patients in less frequently with COVID restrictions, we are now starting to do these again. **You will be called in randomly at least twice per year. You must be present for these pill counts and drug screens. If you do not come in, if you do not return the phone call, or if you fail the pill count or drug screen, your treatment plan could change.** This could mean increased frequency of visits, additional requirements such as counseling, more frequent drug screens and pill counts, or even discontinuation of your medication. It is very important that you come in for these.

What does this mean for me?

- If you are prescribed a controlled substance, you will be called at least twice per year for random pill counts and drug screens and must come in for these. This is a requirement.
- If you receive buprenorphine, you will have a peer support specialist to assist in your care and be expected to interact with them on a regular basis (defined by your medical provider and your PSS).
- Counseling continues to be recommended but is no longer required for all patients. You may be referred to counseling if your medical provider feels this is appropriate.

Please let your provider know if you have any questions, and thank you for receiving your care at Intensive Health!

Please sign to acknowledge you have received this information.

Patient Name: _____

Date of Birth: _____ / _____ / _____

Patient Signature: _____

Date: _____ / _____ / _____

Authorization for Release of Protected Health Information

Patient Name: _____ Date of Birth: ____ / ____ / _____

Social Security Number: _____-_____-_____ Phone Number: (_____) _____ - _____

Location: ☐ London ☐ Woodland ☐ Crowne Pointe ☐ Bowling Green ☐ Nicholasville ☐ Intensive Health ☐ Paducah
☐ Sober Living ☐ IOP/PHP

I authorize Stepworks Recovery Centers to:

☐ RELEASE Medical Records to: ☐ OBTAIN Medical Records from:

Name: _____

Street Address: _____ City: _____ Zip Code: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

I request that my records be ☐ Faxed ☐ Picked up in person ☐ Certified mailed to person/entity above

Initial _____ I request my medical records be sent via unencrypted email. I understand that email is not secure, and any email or email attachment could be intercepted or read by a third party. If you do not consent to this, your records cannot be sent via email.
Email address: _____

Purpose of Request

☐ continuity of care ☐ personal use ☐ vocational rehab
☐ legal circumstances ☐ referral ☐ placement/disposition
☐ insurance ☐ disability determination ☐ other: _____

Information Requested (check all that apply)

All information released may contain private health information related to substance abuse treatment.

☐ discharge summary ☐ intake/assessment ☐ lab results (except HIV/Hepatitis)
☐ HIV and/or hepatitis results ☐ treatment plan ☐ biopsychosocial evaluation
☐ progress notes ☐ medical tests/studies ☐ other: _____

If requesting a specific date or length of stay, please provide that here: ____ / ____ / _____

I understand I can revoke my consent at any time except when disclosure has already taken place, in which case consent will expire on ____ / ____ / _____ or 90 days from the date on which this form was signed. I understand my records may not be released to me at the same time as requested. I understand I am entitled to one free copy of my medical record. Any additional copies will be $1 per page.

This information has been disclosed for records protected by federal confidentiality rules (42 CFR Part 2). Federal rules prohibit anyone from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains 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. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patient.

Patient/Legal Representative Signature: _____ Date: ____ / ____ / _____
Witness Signature: _____ Date: ____ / ____ / _____

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2).
42 CFR Part 2 prohibits unauthorized disclosure of these records.

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201 Peterson Drive, Elizabethtown, KY 42701
(270) 765-5900

Authorization to Release Pharmacy Profile

Fax records to 270-982-1284

Patient Name: _____

Date of Birth: _____ / _____ / _____

Dates Requested: _____ / _____ / _____ to _____ / _____ / _____

Pharmacy Name: _____

Patient Fax: _____

Disclaimer: I hereby authorize the pharmacy listed above to release my pharmacy prescription profile to Stepworks Intensive Health. If the pharmacy is a part of a larger retail organization, I request and authorize the release of all records available from this and other locations. The purpose of this request is for my continued care through a specialized primary care office. I understand that the profile may contain information related to the treatment of mental health, substance use, and/or sexually transmitted diseases. I understand that this authorization shall remain in effect for a period of one year and may be revoked or terminated upon written notice to the pharmacy.

Patient Signature: _____

Date: _____ / _____ / _____