Health Care for the Homeless

INFORMATION RESOURCE CENTER

888/429-3300 • Fax 518/439-7612

#9. CONSENT FORMS

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HCLA 10

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
ADMISSION, DISCHARGE, FOLLOW-UP AGREEMENT POLICY

ADMISSION AGREEMENT: Homeless Health Care Los Angeles (HHCLA) provides free services to all clients who meet the following criteria:

1. An individual must be homeless, near homeless or GR /CalWORKS referred.
   a) an individual is homeless if his/her night-time residence is either an emergency shelter or in the streets, parks, bus station hotel rooms.
   b) an individual is near homeless if s/he is living in and out of single room occupancy hotels or living in substandard conditions to afford rent.
   c) a GR/CalWORKS individual mandated/referred by DPSS to receive drug treatment services.
2. Reside in Los Angeles County.
3. Be 18 years old or older.
4. Be a drug user, excluding alcohol as the primary drug
5. Agree to participate in HHCLA's Outpatient Counseling & Case Management Drug Treatment Program.
6. Agree to participate in weekly individual drug counseling/case management session.
7. Agree to participate in at least two drug education groups per week.
8. Strive to achieve and/or maintain a drug-free lifestyle while in treatment.
9. Work on the treatment goals that you and your counselor agree upon.

DISCHARGE AGREEMENT: After a client has an intake assessment, s/he is assigned a primary drug counselor/case manager who oversees treatment. The client is then considered active. *An active client will be discharged from the program for any of the following reasons (losing their active status):*

1. Non attendance or no contact for 30 days.
2. Non-compliance with the admission, discharge, and follow-up agreement policy.
3. Violent or threatening behavior toward staff or clients.
4. Drug use and illicit drug transactions on premises.
5. Weapons on program premises.
6. Willful destruction of property or vandalism.
7. When medical, psychological or other conditions necessitate referral or transfer to another agency for primary case management or treatment.

A client discharged for any of these reasons may re-enter the program if eligibility criteria still exist and at the discretion of the Substance Abuse Specialist/Clinical Supervisor.

FOLLOW-UP AGREEMENT: A follow-up mail and/or phone contact shall be made within 30 days of the last face-to-face encounter with a client who is no longer in active treatment.

I acknowledge that I have read and understand the Admission, Discharge, and Follow-Up Agreement Policy. I have had an opportunity to discuss it, and any questions I have had have been answered to my satisfaction. I hereby request and consent to outpatient drug counseling/case management services of Homeless Health Care Los Angeles. I further understand this may include the presence and participation of staff, student interns, and volunteers in the health professions. I acknowledge this by my signature:

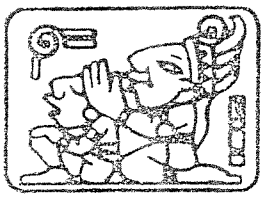
Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HHCLA: 1989, REVISED: 10/01

TER 11

TERRY REILLY HEALTH SERVICES



"Advancing Health In Idaho"

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I, _____, request that the Boise Clinic engage in a

mutual exchange of information in issues relating to my medical/social services care with community agencies which could include but are not limited to the following:

- Ada County Community Services
- Boise Rescue Mission
- Central District Health Department
- Community House
- Department of Health and Welfare
- El Ada
- Gemhaven
- IEP (Idaho Empowerment Program)
- Social Security Administration
- VA Administration
- YWCA Crisis Center

I understand that I am waiving the confidentiality of such information for the limited purpose of facilitating medical and social services from the Boise Clinic. This authorization does not cover release of written medical records.

All records and information obtained/exchanged will be maintained in accordance with federal confidentiality regulations. This release will remain valid as long as medical care and social services are requested from the Boise Clinic.

_____ _____
Signature Date

_____ _____
Witness Date

This consent may be rendered null and void when requested in writing by the client, and signed and dated.

AUTHORIZATION FOR EXCHANGE OF INFORMATION ON AIDS/HIV+ OR SUBSTANCE ABUSE TREATMENT

I request and authorize the Boise Clinic to exchange verbal information specified below to the organizations, agencies, or individuals listed above in this request. I understand that the information to be released includes information regarding the following condition(s):

☐ Drug abuse ☐ Infection with Human Immunodeficiency Virus (HIV) ☐ Alcoholism or Alcohol Abuse

Authorization: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Redisclosure of my medical records by those receiving the above authorized information may not be accomplished without my further written consent.

_____ _____
Signature Date

_____ _____
Witness Date

This consent may be rendered null and void when requested in writing by the client, and signed and dated.

6/2/95 exchinfo.frm

Behavior Contract

Clinic and Community Resource Center Philosophy

Everyone who comes to the Portland Street Clinic Homeless Health Program is responsible for promoting and maintaining a safe and respectful environment.

Every client, staff member, visitor, and volunteer who comes to the clinic can expect to be treated respectfully and feel safe at all times.

Agreement

I _____ agree to abide by the following:

1. I agree to be verbally respectful at all times while in the clinic. I will not use obscene or disrespectful language, make threats, tell abusive jokes or make abusive comments. This includes sexual comments, sexual advances, teasing, insulting, or making fun of others.

2. I agree to be physically respectful at all times while in the clinic. I will not strike, punch, slap or intimidate anyone (even as a joke). I will not damage any property or equipment, or threaten to do so.

3. I will not bring alcohol, illegal drugs, or weapons into the clinic.

4. I accept my personal responsibility to promote and maintain an atmosphere of safety and respect in the clinic and the CRC. I will speak to a staff member if I feel that I am unable to keep the terms of this agreement.

I have read and I understand the above terms of this Behavior Contract, or I have had it read and explained to me. I have been given the opportunity to ask questions, and my questions have been answered satisfactorily. I understand that if I break the terms of this agreement, I could lose clinic (or CRC) privileges and services.

Signature of Agreement_____

Witness_____ Date_____

HCLA 8

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
CHILD ABUSE REPORTING REQUIREMENTS/ ACKNOWLEDGE POLICY

The Penal Code of the State of California requires that any person on or after January 1, 1985, as a child care custodian, medical practitioner, or non-medical practitioner, or with a child protective agency shall sign a statement that he or she has knowledge of the child abuse reporting law and will comply with its provisions. This statement must be signed prior to commencing employment and is prerequisite to employment.

Section 11166 of the California Penal Code, requires any child care custodian, medical practitioner, non-medical practitioner or employee of a child protective agency who has knowledge of or observes a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse to report the known or suspected instance of child abuse to a child protective agency immediately or as soon as practically possible by telephone and to prepare and send a written report thereof within **36 hours** of receiving the information concerning the incident.

Federal Regulations related to the confidentiality of Alcohol and Drug Abuse Client Records, 42 CFR, Part 2, in accordance with the Federal Statute, PL 99-401, the Children's Justice and Assistance Act, enacted on October 1, 1986, provide for the reporting of suspected child abuse and neglect by alcohol and drug treatment programs.

In cases where a client refuses to sign Release of Information forms for Suspected Child Abuse and Neglect, a report may still be filed. It is also possible for a court order to be issued at a later time, for release of client identifying information

EMPLOYEE'S LIABILITY FOR FAILURE TO COMPLY:
Any person who fails to report a case of suspected child abuse as required by this law is guilty of a misdemeanor and is punishable by confinement I the County jail for a term not to exceed six months or by fine of not more than one thousand dollars ($1,000) or both.

I have read and understand the Child Abuse Reporting Policy and I have been informed about the Federal Confidentiality regulations and the California Penal Code requirements on reporting child abuse. I acknowledge this by my signature.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

2330 BEVERLY BLVD., LOS ANGELES, CA 90057 • TEL 213/744-0724 • FAX 213/748-2432

HCLA 18

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

CHILDCARE PROGRAM
AGREEMENT TO PARTICIPATE

I acknowledge I attended the Childcare Orientation and received a copy of the Childcare program Manual. I have had an opportunity to discuss it, and any questions I have had have been answered to my satisfaction. I agree to follow the guidelines as stated in the Childcare Program Manual, and I here request and consent to participate in the Childcare Program.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

REVISED: 10/10

2330 Beverly Blvd., Los Angeles, CA 90057 TEL 213/744-0724 • FAX 213/748-2432

WAI 4

Waikiki Health Center and medical clinic

low-cost general medical care

CLIENT CONSENT TO TREATMENT

Client: _____ File No.: _____

Program: _____

You have the RIGHT and OBLIGATION to make decisions regarding your health care. Your case manager/counselor will provide you with the information necessary for you to enter into the decision-making process regarding your treatment planning. This form is designed to acknowledge your consent to enter into this process with your case manager/counselor. Please feel free to ask any questions.

If you do NOT want detailed information about recommended treatment, please inform your case manager/counselor.

To assist you in making an informed decision, the following will be explained:

1. The nature of the condition being treated.
2. The types of treatment to be used, the reasons for using them, and the anticipated results.
3. The possible alternative treatments available, including your right to non-treatment.
4. That no promise or guarantee can be made to you regarding result or cure.
5. The right to secure a second opinion prior to signing this consent.
6. The right to make any comment you feel you would like to make.

COMMENTS: _____

Your consent to treatment, once given, may be withdrawn at any time by your requesting same to your counselor/case manager. Otherwise, your consent to treatment will expire when your treatment has been terminated.

By signing below, you agree:

1. That you understand this form.
2. That the proposed treatment has been explained to you and discussed by your case manager/counselor.
3. That you have received all the information you want regarding treatment.
4. That you have given us permission to carry out your treatment plan when it is finalized by you and your case manager/counselor.

Date Signed: ___/___/___ Time: _____ Place: _____

_____ _____

Signature of Client Signature of case manager/counselor

TC:HOMEFM Rev.02/88

277 Ohua Avenue · Honolulu, Hawaii 96815-3695 · (808) 922-4787

HIP 3

HOMELESS
INITIATIVE
PROGRAM
1835 N. Meridian Street
Indianapolis, IN 46202

(317) 931-3055
(317) 931-3063 Fax

Street Outreach
•
Medical Care
•
Case Management
•
Pre-Natal Care Coordination
•
Mental Health Counseling
•
Pre-Employment Workshop
•
Skills Training
•
Assisted Job Search

CLIENT PERMISSION TO RELEASE INFORMATION

I hereby give People's Health Center Homeless Initiative Program permission to

☐ Obtain ☐ Release ☐ Discuss

the medical and case management records of

Patient: _____

Previous/Maiden/Other Name Used: _____

Social Security Number: _____--_____--_____

Birthdate: _____/_____/_____

Address: _____

City: _____ State _____ Zip _____

for ☐ Coordinating the patient's care ☐ Other:

for services beginning ____/____/____ and ending _____/_____/_____ (enter dates)

Including ☐ Mental Health ☐ Alcohol Abuse ☐ Drug Abuse ☐ HIV
☐ Communicable Disease ☐ Case Management ☐ Medical care

Excluding ☐ Mental Health ☐ Alcohol Abuse ☐ Drug Abuse ☐ HIV
☐ Communicable Disease ☐ Case Management ☐ Medical care

This permission applies to: (check one)

☐ All agencies and providers involved in the patient's care

☐ Professional/agency listed below (separate form for each)

Professional/agency: _____

Address: _____

City _____ ST _____ ZIP _____

_____ *PLEASE NOTE: Patients enrolled in the Hoosier Healthwise Program with a primary Care Provider must check here as a patient's HIP medical record/case management record will be released to that Provider. Medicaid Dates of service:* _____

People's Health Center releases only medical/case management notes and treatment initiated at this facility.

I understand this release is revocable by writing to stop the release of information and giving or sending my letter to a HIP staff member. I understand that revoking a release will not affect any information ALREADY obtained, released or discussed in the period between the date I sign this and the date of revocation.

Patient/Guardian Signature : _____

Relationship to Patient: _____ Date Signed: _____ (Valid one year)

Witness: _____ Title: _____

YELLOW: Medical Records

HEALTHNET
A HealthNet Community Health Center

BAL 27

CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE CLIENTS

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by Federal Law and Regulations. General, the program may not say to a person outside the program that a patient attends the programs, or disclose any information identifying a patient as an alcohol or drug abuser Unless:

1. The patient consents in writing
2. The disclosure is allowed by a court order or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluations.

Violations of the Federal Law and Regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal Regulations.

Federal Laws and Regulations do not protect any information about a crime committed by a patient either at the programs or about any threat to commit such a crime.

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.

I understand that Health Care for the Homeless is a recipient of Ryan White CARE Act funds, which are used to support my care. Health Care for the Homeless is required to report statistical and demographic data to the Health Resources and Services Administration. No identifying information such as name, address is ever reported and data are always reported in a summary format. Additional client level data related to my specific care plan may also be reported.

I _____ have received and understand the
[Print Name of Client]

above notice concerning my confidentiality rights at Health Care for the Homeless. I have also received a copy of these rights.

_____ _____
Signature of Client **Date**

_____ _____
Signature of Witness **Date**

CLIENT LAST NAME: **FIRST:** **HCH#:**

HCLA 6

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
CONFIDENTIALITY OF CLIENT RECORDS

Confidentiality of client records is maintained by Homeless Health Care Los Angeles (HHCLA) and is protected by Federal law and regulations. HHCLA will not report that a person is a HHCLA client ***unless***:

1. The client consents in writing.
2. The disclosure is allowed by a court order.
3. The disclosure is made to medical personnel in a medical emergency or to a qualified person for research, audit, or program evaluation purposes.

Limits to confidentiality are:

1. Child Abuse,
2. Elder Abuse,
3. Dependent adult abuse,
4. Danger to others (Duty to Warn),
5. Danger to self (Right to Warn),
6. Danger to property (Right to Warn).

Violation of the Federal law and regulation by a program 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 a client either at the program or against a person who works for the program or about any threat to commit such a crime.

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. (See 42 U.S.C. 290dd-3 42 USC 290ee-3 for Federal laws and CRF Part 2 for Federal regulations.)

I have read and understand the Confidentiality of Client Records Policy and acknowledge this by my signature.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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MONTEFIORE
New York Children's Health Project
Division of Community Pediatrics

MON 11

CONSENT FOR DEPO-PROVERA

NAME : LAST	FIRST	
MR # |__|__|__|-|__|__| -|__| |__|-|__|__| - |__|__|		DATE OF SERVICE

❒ Need to use back-up method first 24 hours after injection
❒ Does not protect against STD's
❒ Advantages
◆ extremely effective in preventing pregnancy (failure rate 3/1000 users) ◆ last for 12 weeks ◆ nothing to remember every day or every time you have sex ◆ less menses over time ◆ decreased anemia ◆ decreased menstrual cramps

❒ Side Effects (most common)
◆ irregular menstrual bleeding; bleeding more days than usual, spotting between periods, no periods--this is the most common side effect, especially during the first 6 months of use. Many women will stop having their periods after one year of use. ◆ weights gain (2-5 pounds/year, for first 3 years of use)◆ HDL "good" cholesterol levels fall significantly

❒ Other possible side effects
◆ depression ◆ headaches ◆ premenstrual like symptoms ◆ premenstrual like symptoms ◆ acne

❒ There is no way to reverse Depo-Provera and the side effects may continue until the shot wears off (3-4 months).
❒ There may be tenderness, soreness and/or bruising for a couple of days after the shot is given at the injection site.
❒ Smoking cigarettes increases the risk of serious side effects (e.g. blood clots, heart attacks, stroke) with the pill, especially after age 35 and if more than 15 cigarettes are smoked per day. It is not known if this will happen with Depo-Provera. It is advised not to smoke cigarettes.
❒ Some serious problems have occurred with the birth control pill. Although it is less likely these problems will occur with Depo-Provera, there is the possible risk of:
◆ blood clots in the leg ◆ stroke or heart attack ◆ ectopic pregnancy ◆increased cholesterol

❒ Theoretical increased risk of the above health problems when you:
◆ smoke more than 15 cigarettes per day ◆ are 35 years or older ◆ have high blood pressure ◆ are over weight

❒ You cannot use Depo-Provera if you:
◆ are pregnant ◆ have or in the past have had blood clots ◆ have or in the past have had breast cancer
◆ have or in the past have had liver or gall bladder disease
◆ have unexplained vaginal bleeding ◆ have know allergy to Depo-Provera or any of its ingredients

❒ **DANGER SIGNS TO WATCH FOR AND REPORT!**
◆ severe pain or swelling in the legs ◆ heavy or prolonged vaginal bleeding
◆ sharp or crushing chest pain or coughing blood ◆ shortness of breath ◆ sudden severe headaches ◆ blurred, double or loss of vision
CALL US AT 1-800-4BLUEVAN IF YOU HAVE ANY PROBLEMS OR QUESTIONS. IN CASE OF ANY OF THE DANGER SIGNS GO TO THE EMERGENCY ROOM OF THE CLOSEST HOSPITAL.

The above risks and benefits have been explained to me by _____ . My questions have been answered. I understand that I must return in 12 weeks for another injection of Depo-Provera if I want to continue using it for birth control. I also understand that Depo-Provera does not protect against sexually transmitted diseases, including HIV and I must use condoms to protect myself against this. I hereby request that I be given Depo-Provera.

Patient's Signature: _____ Date: ___/___/___

Witness _____ Date ___/___/___

Clinician _____ Date ___/___/___

BIR 6

Birmingham Health Care for the Homeless Coalition, Inc.

P.O. Box 11523, Birmingham, Alabama 35202

Consent for Follow-Up Evaluation / Consent to Release Information

1. BHC Substance Abuse/Mental Health and Case Management Programs performs regular follow-up evaluations on each of its discharged patients. For this purpose, a member of the staff from the Substance Abuse/Mental Health or Case Management Programs will contact you, and/or someone close to you, within six (6) months from the date of last service for the purpose of determining their continuing progress towards or maintenance of treatment plan outcomes.

2. I hereby authorize the BHC Substance Abuse/Mental Health or Case Management Programs to contact me for information concerning my recovery status after discharge from treatment.

3. I also consent to have BHC Substance Abuse/Mental Health or Case Management Programs contact the person(s) listed below to confirm any information concerning my recovery:

NAME	ADDRESS	PHONE

4. I understand that my records are protected under FEDERAL CONFIDENTIALITY REGULATIONS (Federal Register, Part IV, July 1, 1975) and cannot be disclosed without my written consent unless otherwise provided for in this regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) And that in any event, this consent expires automatically one (1) year and (1) month after the date of my discharge from treatment at BHC Substance Abuse/Mental Health or Case Management Programs.

Patient: _____
(Please Print Patient Name)

Signature: _____ Date: _____
(Patient, Parent, Legal Guardian)

Witness: _____

POR 4

City of Portland Public Health Division --Health Care for the Homeless Program

Consent for HIV Viral Load Analysis (HIV viral RNA)

It has been recommended by my medical provider that I have blood drawn for HIV viral load. Viral load measures the amount of HIV virus in my blood, and helps to determine the degree to which the HIV virus may be affecting my immune system.

Purpose

Viral load for HIV is part of the medical work-up (a part of the "big picture") which will help me and my medical providers to understand the status of my HIV infection. Knowing this information is important for my medical care. My medical providers may recommend that I have this test done periodically.

Risks & Benefits

I understand that having my blood drawn for HIV viral load carries minimal risks. I may experience discomfort and bruising at the site of the needle stick. If my viral load is high, I may experience emotional stress. Knowing my HIV viral load may be of benefit to me because, by knowing the amount of HIV virus in my blood, my medical providers can develop more specific and appropriate treatment plans, including offering the right medication.

Disclosure

I understand that the results of this test will become a part of my medical record, which is confidential. This information can only be disclosed to persons who have appropriate access to these records, i.e., members of the health care team involved in my care, my "legal guardian(s)," the Maine Department of Corrections (if I am in its custody), and the Department of Human Services when required by law. My medical records can be released to others, only with my written authorization.

Consent

I am giving my permission to be tested for HIV Viral Load of my own free will. Any questions I have about HIV Viral Load and the nature & meaning of the test have been answered satisfactorily. I understand the risks and benefits. I have read this consent form, or it has been thoroughly explained to me.

_____ _____

Patient or Guardian Date

_____ _____

Witness Date

BAL 12

111 PARK AVENUE ▲ BALTIMORE, MARYLAND 21201 ▲ 410-837-5533 ▲ Fax: 410-837-8020

HEALTH CARE FOR THE HOMELESS

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, _____, _____,
Name SSN# Date of Birth

authorize Health Care for the Homeless - 111 Park Avenue - Baltimore, MD 21201- (410) 837-5533

to furnish information to the following persons/institutions:

_____
(Name)

_____
(Mailing Address)

_____
(City/State/Zip Code)

This information is to be limited to the following:

- ☐ History and Physical
- ☐ Medical Progress Note
- ☐ Nursing Notes
- ☐ Medication Sheet
- ☐ Labs / X-Rays / Consultations
- ☐ Mental Health Records
- ☐ Addictions Records
- ☐ Social Service Records
- ☐ Other: _____
- ☐ The information designated above is intended to include information received from a third party provided the third party has not prohibited re-disclosure.

This information is to be released for the purpose of continuity of medical care.

I understand that my records are protected under federal, state confidentiality regulations, and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e., information released prior to revocation), and that unless an earlier expiration is provided for below, this content automatically expires in one (1) year.

I understand that my medical records may contain information about such things as alcohol, drug use and/or HIV status.

This authorization shall become effective immediately and shall be valid until: _____

Executed this _____ day of _____ 20____.

_____ _____
(Client Signature) (Witness Signature)

HOM 8

HOMES Inc.

Housing Opportunities Management and Essential Services, Inc.

408 East State Street • Ithaca, New York 14850 (607) 272-1741

COMMUNITY LIVING SERVICES
CONSENT FOR RELEASE OF INFORMATION FORM

NAME: _____ DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

Extent or Nature of Information to be Disclosed:
Psychiatric Evaluation(s); Psychological Testing; Psychosocial; Medical, treatment & discharge summaries.

Purpose or Need for Information:
Admissions/Discharge Purposes; Coordination of Services.

I, _____, hereby give my consent to the individuals listed below to share written and verbal information regarding my involvement with each. I understand that all information shared will be used to coordinate services in my best interest and that each individual will maintain the confidentiality of the information.

I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released and that this consent is valid _____ or unless revoked by me.

Consent is granted to the following individuals or agencies:

Tompkins County Screening Committee
H.O.M.E.S., Inc. Staff
Community Support Services
Tompkins County Mental Health Services

_____ _____
Signature of Resident Date

_____ _____
Signature of Witness Date

_____
Resident's Address

1/93

HCLA 7

HOMELESS HEALTH CARE
LOS ANGELES

HOMELESS HEALTH CARE LOS ANGELES
CONSENT FOR RELEASE OF INFORMATION
UNDER LANTERMAN-PETRIS-SHORT ACT

I hereby authorize _____ to disclose records
PRACTITIONER/AGENCY

and/or information regarding _____ DOB: _____
CLIENT NAME

obtained in the course of treatment to: _____
STAFF NAME/TITLE
Homeless Health Care Los Angeles
2330 Beverly Blvd.
Los Angeles, CA 90057

The disclosure of records authorized herein is required for the following purposes:_____
_____

California Welfare and Institution Code Section 5328 protect these records. Disclosure shall be limited to the following information specified below:

☐ Diagnosis
☐ Discharge Summary
☐ Psychological/Vocational Test Results
☐ Other: _____

An additional consent must be obtained for any other transfer or disclosure of information. This authorization shall become effective _____ and is subject to revocation by the
DATE

undersigned at any time except to the extent that the action has already been taken. If not

earlier revoked, this consent shall terminate on _____.
DATE

Termination date should not be more than 90 days from the effective date unless the treatment plan justifies on-going communication with the above named agency. Under no circumstances should the termination date exceed one year.

This authorization gives permission to have information released between the individual(s) and agency(s) listed above. I understand that this consent to release information waives any of my rights, currently or in the future, to bring any legal action against the releasing person/agency for any caused damages directly or indirectly by the release of this information.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

BIR 5

Birmingham Health Care for the Homeless Coalition, Inc.
P.O. Box 11523, Birmingham, Alabama 35202

CONSENT FOR TREATMENT

I, _____, hereby authorize the performance of any diagnostic, therapeutic, or other medical procedure which may be advised and recommended by the Health Care team of Birmingham Health Care for the Homeless Coalition, Inc.

Patient: _____
(Please Print Patient Name)

Signature: _____
(Patient, Parent, Legal Guardian)

Witness: _____

Date: _____

BAL 33

GROUP IMMUNIZATION
INFLUENZA (FLU) VACCINE

Patient Information

Flu

Influenza (flu) is a respiratory disease caused by influenza virus infection. The types, or strains, of influenza virus that cause illness may change from year to year, or even within the same year. People who get flu may have fever, chills, headache, dry cough, and muscle aches, and may be sick for several days to a week or pneumonia or other complications, including death, may occur.

Flu Vaccine

The regular flu vaccine contains killed influenza virus of the types selected by the U.S. Public Health Service and the Center for Biologics Evaluation & Research of the U.S. Food and Drug Administration. The types of virus included are those that have most recently been causing influenza. The vaccine will not give up flu because it is a virus vaccine. As with any vaccine, flu vaccine may not protect 100% of all susceptible individuals.

Possible Side Effects

Influenza vaccine generally causes only mild side effects that occur at low frequency. Most commonly, the reactions may be a sore or tender arm where the injection was given, or possible fever, chills, headache, or muscle aches. These side effects usually last 24 to 48 hours. Most people who receive the vaccine either have no reaction or only mild reactions. There is a possibility, as with any vaccine or drug, that an allergic or other serious reaction, or even death, could occur. Also, medical events completely unrelated to the vaccine may occur coincidentally following vaccination.

Unlike the 1976 swine influenza vaccine, flu vaccines, used since then have not been clearly connected with an increased frequency of Guillain-Barré syndrome, which is associated with paralysis.

Vaccination is generally not recommended for the following people:

1. People allergic to eggs or egg products
2. People sensitive to thimerosal (a substance used as an antiseptic and germ killer)
3. People who have an active nerve disorder
4. People with a fever, or active respiratory or other infection or illnesses.

If you have any of the above, please notify the staff. If you have any questions, please ask now or check with a physician or your health department before receiving the vaccine.

If you experience any significant reactions, see your physician

I have read the above information about influenza vaccine and I have had a chance to ask questions. I have received a copy of the influenza vaccination safety sheet. I understand the benefits and risks of influenza vaccination and request that the vaccine be given to me.

_____

Client Signature

CLIENT LAST NAME:		FIRST:		HCH#:	

BAL 37

Informed Consent and Agreement to HIV Testing

I understand the following information, which I have read or have been read to me:

- Blood or another body fluid or tissue sample, will be tested for the human immunodeficiency virus (HIV), the virus that causes AIDS.
- Consent to be tested for HIV should be given FREELY.
- Results of the test, like all medical records, are confidential, but confidentiality cannot be guaranteed.
- If positive test results become known, an individual may experience discrimination from family or friends and at school or work.

What a NEGATIVE Result Means:

- A negative test means that HIV infection has not been found at the time of the test.

What a POSITIVE Result Means:

- A positive HIV test means that a person is infected with HIV and can transmit the virus by having sex, sharing needles, childbearing (from mother to child), breastfeeding, or donating organs, blood, plasma, tissue, or breast milk.
- A positive HIV test DOES NOT mean a diagnosis of AIDS - other tests are needed.

What will happen if the Test if Positive:

- A copy of the Department of Health and Mental Hygiene's publication "Information for HIV Infected Persons" will be provided.
- The local health department or my doctor will offer advice about services which are available.
- Women who are pregnant or may become pregnant will be told of treatment options which may reduce the risk of transmitting HIV to the unborn child.
- Information will be provided on how to keep from transmitting HIV infection.
- My Unique Identifying Number (UI) will be given to the health department.
- My name will be reported to the local health department when my doctor finds that I have symptoms of HIV disease or AIDS.
- The local health department or my doctor will offer assistance in notifying and referring my partners for services. If I refuse to notify my partners, my doctor may notify them or have the local health department do so. If local health department staff notify my partners, my name will not be used. Maryland laws requires that when the local health department knows of my partners, it must refer them for care, support and treatment.

I have checked below if I do not want the last 4 digits of my Social Security number used to create a Unique Identifying (UI) number.

_____ **I DO NOT Authorize** the use of the last 4 digits of my Social Security number to create a Unique Identifier.

I have been given a chance to have my questions about this test answered. **I hereby agree to be tested for HIV.**

Print Name of Person Tested	Date
Signature of Person or Authorized Substitute	Date
Signature of Counselor	Date

UI NUMBER

last 4 digits ss#	date of birth			race/ethnicity	sex
☐☐☐☐	☐☐	☐☐	☐☐☐☐	☐	☐
	m m	d d	y y y y		

CODES					
RACE/ETHNICITY:	❶ White, Not Hispanic ❷ Af. Am., Not Hispanic ❸ Hispanic	❹ Asian/Pacific Is. ❺ Am. Indian/Ak. Native ❻ Other	❾ Undetermined	SEX:	❶ Male ❷ Female

CLIENT LAST NAME:		FIRST:		HCH#:	

POR 4a

Public Health Division

CITY OF PORTLAND

Health Care for the Homeless + Portland Street Clinic
15 Portland Street, Portland, Maine 04101

PERMISSION TO RELEASE HIV VIRAL LOAD ANALYSIS AS PART OF MEDICAL RECORD

Sometimes you may want your medical record sent to somebody else, such as another clinic, a hospital, or a doctor. If you apply for SSI, they will need to see your medical record. Anyone wanting your medical record must have you sign a medical release of information form. This form must be signed and sent to us before we can release your records.

Your HIV Viral Load test information can't be given to anyone requesting your medical record unless you have also given your written permission for us to send it along with the medical record. By signing below, you agree to make a choice now, with the understanding that you can change your mind at any time by signing a new form.

****

YES, I want my HIV VIRAL LOAD test information sent with my medical record when I give permission for someone to get my medical record.

_____ _____
Signature Date

_____ _____
Witness/Nurse Date

****

NO, I DO NOT want my HIV VIRAL LOAD test information sent with my medical record when I give permission for someone to get my medical record.

_____ _____
Signature Date

_____ _____
Witness/Nurse Date

MER 6

RELEASE AUTHORIZATION

DATE:_____

I hereby authorize _____ to send the immunization record from my own (child's) medical record to the Health Care for the Homeless/ Mercy Hospital. Address listed below.

NAME_____

MOTHER'S NAME_____ SS#_____ D.O.B._____

Immunization	Date	Immunization	Date	Immunization	Date	Special Tests	
DTP #1		POLIO #1		MMR (combined) #1		Tuberculin Test	
#2		Oral #2		#2		Result	Date
Diphtheria #3		Trivalent #3		Tetanus Toxoid			
Tetanus #4		(TOPV) #4		Hib #1			
Pertussis #5				#2			
				#3			
				#4			
Tetanus		Measles		Hepatitis B #1		Lead Test	
Diphtheria		Mumps		#2			
Adult Type		Rubella		#3			
OTHER							

_____/_____
R. N. Date

_____/_____
Guardian/Parent Date

THIS AUTHORIZATION MAY BE REVOKED BY ME AT ANY TIME, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE THEREON. THIS AUTHORIZATION, UNLESS EXPRESSLY REVOKED EARLIER, WILL EXPIRE NINETY (90) DAYS FROM THE DATE OF SIGNATURE.

RETURN TO: Health Care for the Homeless/MERCY HOSPITAL

271 Carew Street, P.O. Box 9012 Springfield, MA 01102-9012 (413) 748-9064 Fax (413) 748-9049
A member of the Sisters of Providence Health System

BAL 13

111 PARK AVENUE ▲ BALTIMORE, MARYLAND 21201 ▲ 410-837-5533 ▲ Fax: 410-837-8020

HEALTH CARE FOR THE HOMELESS

REQUEST FOR MEDICAL RECORDS FROM ANOTHER FACILITY

Date: _____

To: _____
(Name of medical facility)

_____
(Address)

_____
(City / State / Zip Code)

I, _____, _____, _____
(please print patient name) (social security number) (date of birth)

hereby authorize and request you to release copies of all my medical care to:

HEALTH CARE FOR THE HOMELESS
111 PARK AVE.
BALTIMORE, MD 21201
Phone: 410-837-5533

Please include the following information:

- ☐ History and Physical
- ☐ Medical Progress Note
- ☐ Nursing Notes
- ☐ Medication Sheet
- ☐ Labs / X-Rays / Consultations
- ☐ Mental Health Records
- ☐ Addictions Records
- ☐ Social Service Records
- ☐ Other: _____

Dates of Service from: _____ to _____

This authorization shall remain in effect until: _____

_____
Signature

_____
Witness

HCLA 9

HOMELESS HEALTH CARE
LOS ANGELES

Homeless Health Care Los Angeles

DRUG ABUSE HOMELESS DAY CARE SERVICES
SEXUAL CONDUCT POLICY

Sexual contact shall be prohibited between clients and al program staff, including members of the Board of Directors. Homeless Health Care Los Angeles (HHCL) shall include a statement in each employee's personnel file noting that the employee has read and understands the sexual contact prohibition policy.

Drug Abuse Homeless Day Care Services case managers counselors shall include the policy prohibition as part of an overall client's rights statement given to the client at admission. The policy shall remain in effect for six months after a client is discharged.

I have read the above policy related to sexual conduct and I agree to abide by the above statement. I acknowledge this by my signature.

Client Signature: _____ Date: _____

Staff Signature: _____ Date: _____

HHCLA: 1990, REVISED 10/01

2330 BEVERLY BLVD., LOS ANGELES, CA 90057 TEL 213/744-0724 • FAX 213/748-2342

BAL 41

HEALTH CARE FOR THE HOMELESS, INC.

111 Park Avenue
Baltimore, Maryland 21201

STATEMENT OF CLIENT DECLINATION OF ADVICE OR PLAN OF CARE OFFERED AT HEALTH CARE FOR THE HOMELESS

My signature below indicates that I have chosen to not follow the advice of the health care providers(s) at Health Care for the Homeless, who have advised me regarding:

_____

_____

I have been informed by the provider at Health Care for the Homeless of the potential dangers which may result in my not following the above plan of care that could include:

_____

_____

I assume full and complete responsibility for any results caused by my not following the above plan of care. I hereby release Health Care for the Homeless, Inc. Baltimore, MD, its employee, officers, agents and health care providers who offered the above plan of care/advice from any and all liability.

DO NOT sign this form unless you have read it (or had it read to you), understand it and agree with what is says.

_____
Client Signature

_____ _____
Provider Signature **Date and Time**

_____
Witness Signature

CLIENT LAST NAME: _____ FIRST: _____ HCH#: _____

CHC 1

Chattanooga-Hamilton County
Health Department
921 East Third Street
Chattanooga, Tenn. 37403-2165

TRANSLATION SERVICES CONSENT

I, _____, hereby give _____
(Patient) (Interpreter)
permission to act as interpreter during my visit to the Chattanooga-Hamilton County Health Department on _____(date) and for any subsequent visits.

_____ _____
Signature Date Witness Date

I understand that all information exchanged is to be kept confidential. I will not discuss the above named individual or any details of their medical care with anyone outside the Chattanooga-Hamilton County Health Department.

_____ _____
Signature Date Witness Date

DEPARTMENTO DE SALUD

Yo, _____, doy _____ el permiso para actuar de interprete durante mi visita en el Departmento de Salud de Hamilton County despues de esta fecha, y para otras visitas.

_____ _____
Firma Fecha Testigo Fecha

Yo entiendo que toda la informacion en este intercambio sera confidencial. No hablare sobre el cuidado medico de la persona identificada con nadia fuera del Departmento de salud de Hamilton County.

_____ _____
Firma Fecha Testigo Fecha

City of Portland, Health & Human Services Department, Public Health Division
Healthcare for the Homeless, Mental Health & Substance Abuse Services

Treatment Plan - Review

Side 1 of 2

Name: SS #: DOB:

I have read the review of my treatment plan or have had it explained to me. I understand the purpose, benefits and risks of this treatment plan. I have had the opportunity to ask any questions I might have about my care.

I agree with the treatment plan review and have been offered a copy.

****

Review #1 / comments:

Date: Client's/Guardian's signature:

Staff signature :

****

Review #2/ comments:

Date: Client's/Guardian's signature:

Staff signature:

City of Portland, Health & Human Services Department, Public Health Division
Healthcare for the Homeless, Mental Health & Substance Abuse Services

Treatment Plan - Review

****

Review #3/ comments:

Date: Client's/Guardian's signature:

Staff signature

****

Review #4/ comments:

Date: Client's/Guardian's signature:

Staff signature