AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT INFORMATION

PATIENT					
DOB		AHCCCS ID #		PHONE #	

I. AUTHORIZATION

I authorize Jacob's Hope to disclose, or receive, the following information relating to the treatment and/or condition of the patient described above (**initial all that apply**):

_____(Initial) Health information relating to the treatment or condition.

This authorization includes treatment or condition records related to:

_____(Initial) Behavioral health treatment records, including records for Substance Use Disorder treatment including records protected by 42 C.F.R.

Part 2; _____(Initial) Sexually transmitted disease records; _____(Initial) HIV/AIDS test results.

II. Need for Information

☐ - Continuing Medical Care ☐ - Insurance ☐ - Billing ☐ - Case Management ☐ - Legal Purposes

III. Information to be Released

☐ - Treatment History ☐ - Consultation Reports ☐ - Lab/Path/X-Ray Reports and Images ☐ - Face Sheet

IV. Information is Being Released to:

V. Terms

I understand that these records are confidential and cannot be disclosed without written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that this authorization may be revoked in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire twelve (12) months from the date of the signature unless the authorization is revoked prior to that time.

The representative will receive a copy of this authorization after it is signed. A copy of this authorization is as valid as the original.

PATIENT IS LESS THAN ONE YEAR OLD SO AUTHORIZATION IS BY

☐ - Medical Director ☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other:

	RELEASING REPRESENTATIVE	LEGALLY AUTHORIZED REPRESENTATIVE
Signature		
Printed Name		
Role		
Date		

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

	Jacob's Hope 1150 N Country Club Dr, Ste 12 Mesa, AZ 85201 EIN 37-1828794 ADHS Lic: IFBH9411 NPI: 1811454754 AHCCCS: 492287

1. CONSENT TO TREAT. The Arizona Dept. of Economic Security (the "Division") and the Arizona Health Care Cost Containment System ("AHCCCS") recognizes two primary types of consent for medical or behavioral health services: general consent and informed consent.

   Prior to obtaining informed consent, an appropriate behavioral health representative, as identified in A.A.C. R9-21-206.01(c), must present the facts necessary for a member/responsible person to make an informed decision regarding whether to agree to the specific treatment and/or procedures.

   Documentation that the required information was given and that the member/responsible person agrees or does not agree to the specific treatment, and the member's/ responsible person's signature when required, must be included in the clinical record.

   In addition to general and informed consent for treatment, state statute (A.R.S. § 15-104) requires written consent from a *child's parent or legal guardian* for any behavioral health service including, but not limited to admission for medical detoxification, an inpatient facility, or a residential program.

2. GENERAL REQUIREMENTS FOR CONSENT.
   a. In accordance with A.R.S. § 36-2272, except as otherwise provided by law or a court order, no person, corporation, association, organization, state-supported institution, or any person employed by any of these entities, may procure, solicit to perform, arrange for the performance of, or perform, mental health screening in a nonclinical setting or mental health treatment on a minor without first obtaining consent of a parent or a legal custodian of the minor child. If the parental consent is given through telemedicine, the health professional must verify the parent's identity at the site where the consent is given. This section does not apply when an emergency exists that requires a person to perform mental health screening or provide mental health treatment to prevent serious injury to or save the life of a minor child.
   b. Any person, aged 18 years and older, in need of behavioral health services, must give voluntary general consent to treatment, demonstrated by the member's or legal guardian's signature on a general consent form, before receiving behavioral health services.
   c. For members under the age of 18, the parent, legal guardian, or a lawfully authorized custodial agency (including foster care givers A.R.S. § 8-514.05[C]) must give general consent to treatment, demonstrated by the parent, legal guardian, or a lawfully authorized custodial agency representative's signature on a general consent form prior to the delivery of behavioral health services.
   d. When treating members in an emergency, Jacob's Hope is not required to obtain general consent prior to the provision of emergency services. Providers treating members pursuant to court order must obtain consent, as applicable, in accordance with A.R.S. § 36-501 et seq.
   e. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed may giver consent for:
      i. Evaluation and treatment for emergency conditions that are not life threatening, and
      ii. Routine medical and dental treatment and procedures, including Early Periodic Screening Diagnosis and Treatment (EPSDT) services, and services by health care providers to relieve pain or treat symptoms of common childhood illnesses or conditions (A.R.S. § 8-514.05[C]).
   f. To ensure timely delivery of services, consent for intake and routine behavioral health services may be obtained from either the foster caregiver or the Department of Child Safety Specialist (DCSS), whomever is available to do so immediately upon request (A.R.S. § 8-514.05[C]).
   g. A foster parent, group home staff, foster home staff, relative, or other person or agency in whose care a child is currently placed must not consent to:

i. General anesthesia;
ii. Surgery;
iii. Testing for the presence of the human immunodeficiency virus;
iv. Blood transfusions; or
v. Abortions.

h. Foster or kinship caregivers may not consent to terminate behavioral health treatment. The termination of behavioral health treatment requires DCS consultation and agreement.

i. If the foster or kinship caregiver disagrees on the behavioral health treatment being recommended through the Child and Family Team (CFT), the CFT including the foster or kinship caregiver and DCS caseworker should reconvene and discuss the recommended treatment plan. Only DCS can refuse consent to medically recommended behavioral health treatment.

3. DOCUMENTING INFORMED CONSENT

a. The child's parent, guardian or custodian, must give informed consent for treatment by signing and dating an acknowledgment that he or she has received the information and gives informed consent for the proposed treatment.

b. When informed consent is given by a third party, the identity of the third party and the legal capability to provide consent on behalf of the member, must be established. If the informed consent is for psychotropic medication or telemedicine and the member, or if applicable, the responsible person, refuses to sign an acknowledgment and gives verbal informed consent, the medical practitioner must document in the member's record that:
i. The information was given
ii. The member refused to sign an acknowledgment
iii. The member gives informed consent to use psychotropic medication or telemedicine.
iv. When providing information that forms the basis of an informed consent decision for the circumstances identified above, the information must be:
1. Presented in a manner that is understandable and culturally appropriate to the member, parent, legal guardian or an appropriate court;
2. Presented by a credentialed behavioral health medical practitioner or a registered nurse with at least one year of behavioral health experience.

It is preferred that the prescribing clinician provide information forming the basis of an informed consent decision. In specific situations in which it is not possible or practicable, information may be provided by another credentialed behavioral health medical practitioner or registered nurse with at least one year of behavioral health experience.

c. Written informed consent must be obtained from the member, legal guardian, or an appropriate court, prior to the member's admission to any medical detoxification program, inpatient facility, or residential program, operated by a behavioral health provider.

d. If informed consent is revoked, treatment must be promptly discontinued, except when abrupt discontinuation of treatment may pose an imminent risk to the member. In such cases, treatment may be phased out to avoid any harmful effects.

4. If someone other the child's parent intends to provide general or informed consent to treatment, the following documentation must be obtained and filed in the child's clinical record.

Individual/Entity	**Documentation**
Legal Guardian	Copy of court order assigning custody
Relatives	Copy of Power of Attorney Document
Other Person/Agency	Copy of Court Order Assigning Custody
DCS Placements (for children removed from home by DCS), such as: Foster parents; Group home staff; Foster home staff; Relatives; Other person/agency in whose care DCS has placed the child	None required, with caveat below: *If behavioral health providers doubt whether the person bringing the child in for services is a person/agency representative in whose care DCS has placed the child, the provider may ask to review verification, such as documentation given to the person by DCS indicating that the person is an authorized DCS placement. If the person does*

	not have this documentation, the provider may also contact the child's DCS caseworker to verify the person's identity.

5. By my signature below, I, the patient representative, hereby give my consent to Jacob's Hope, its agents, and health care providers including contracted physicians and/or his/her designated healthcare specialist for the evaluation, diagnostics, testing, and treatment including, but not limited to treatment for behavioral health needs/substance use disorder (especially Neonatal Abstinence Syndrome). I understand that I may request and receive information on the specific affiliation(s) of any particular healthcare provider I encounter during my care.

6. I voluntarily request a physician, or the physician's designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me, or the person in my care, to seek care at this practice or one that has been identified. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

7. I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Individual/Entity Providing Consent, if Applicable:	Jacob's Hope Staff:
_____	_____
Signature	Signature
_____	_____
Printed name	Printed name
_____	_____
Parent/Relative/Other Person/Agency	Position
_____	_____
Date	Date

Patient Transfer Agreement

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WHEREAS, both ORIGINATING and RECEIVING facilities desire, by means of this Agreement, to assist physicians, nurses, pharmacists, other healthcare providers/practitioners, and the parties hereto in the treatment of infants requiring sub-acute care; and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of patients transferred, (b) the continuity of the care and treatment appropriate to the needs of patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional health care of patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

1. PATIENT TRANSFER: The need for transfer of a patient from ORIGINATING to RECEIVING facility shall be determined and recommended by the patient's attending physician in such physician's own medical judgment. When a transfer is recommended as medically appropriate, a patient at ORIGINATING facility shall be transferred and admitted to RECEIVING Facility as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by RECEIVING facility will be made pursuant to admission policies and procedures of RECEIVING facility.

2. ORIGINATING facility agrees that it shall:

    a. Notify RECEIVING facility as far in advance as possible of transfer of a patient.

    b. Transfer to RECEIVING facility the personal effects and information relating to same.

    c. Make every effort within its resources to stabilize the patient to avoid all immediate threats to the patient. If stabilization is not possible, ORIGINATING facility shall not transfer the patient to the RECEIVING facility described in this Agreement.

    d. Affect the transfer to RECEIVING facility through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

3. ORIGINATING facility agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

Patient Transfer Agreement

4. RECEIVING FACILITY agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

5. Bills incurred with respect to services performed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

6. This Agreement shall be effective from the date of execution.

7. Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

9. Nothing in this Agreement shall be construed as limiting the right of either Party to affiliate or contract with any hospital or licensed health facility on either a limited or general basis while this Agreement is in effect.

10. Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

11. This Agreement shall be governed by the laws of the State of ARIZONA.

12. Both parties agree to comply with all relevant and applicable state and federal laws.

13. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

14. Neither party makes any implied or express representation, warranty, or indemnification to the other related to this Agreement. Both parties are fully responsible for their own services, staff, and care delivered to the patient. The RECEIVING facility shall have no liability to the patient prior to execution of this Agreement and prior to arrival at Receiver facility.

ORIGINATOR:	RECEIVER:
_____	_____
Signature	Signature
_____	_____
Printed name	Printed name
_____	_____
Position	Position
_____	_____
Date	Date

9/21/2022