Authorization for Release of Medical Information
Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I

_____ hereby authorize. The following individual or Organization is authorized to release the following.

_____
(Name of someone whom you approve to have access to your records or Organization)

_____
(Address)

_____
(Telephone/Fax)

To use or disclose the following protected health information from my medical record as instructed by me:

[ ] The entire medical record [ ]Appointments [ ] Test results [ ] Pay for your office visits

[ ] Specific parts of the medical record [ ] Leave messages for Doctor or Therapists [ ] Speak with staff

[ ] Colbaration with organization for continued care or to set up continued care

The information is to be disclosed to: Advanced Psychiatric Care PC, 6700 Winkler Road, Unit 4, Fort Myers, FL. 33919

I understand that I may revoke this authorization, at any time, by writing to the Privacy Officer, at which time it will go into effect. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on 90 days, or _____. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS,HIV, and or sexually transmitted disease, and all other sensitive information.

**If you would prefer NO ONE have access to your record please initial _____**

I fully understand and accept the terms of this authorization.

_____ _____
Patient/Legal Representative Signature Date

Patient Name:_____ Today's Date:_____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an 'X' in the box that best describes how you have felt and conducted yourself over the past 6 months. Box '0' being never; box '1' being rarely; box '2' being sometimes; box '3' being often; box '4' being very often. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

| | 0 | 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|
| 1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done? | | | | | |
| 2. How often do you have difficulty getting things in order when you have to do a task that requires organization? | | | | | |
| 3. How often do you have problems remembering appointments or obligations? | | | | | |
| 4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started? | | | | | |
| 5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time? | | | | | |
| How often do you feel overly active and compelled to do things, like you were driven by a motor? | | | | | |
| 7. How often do you make careless mistakes when you work on a boring or difficult project? | | | | | |
| 8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work? | | | | | |
| 9. How often do you have difficulty concentrating on what people say? | | | | | |
| 10. How often do you misplace or have difficulty finding things at home or at work? | | | | | |
| 11. How often are you distracted by activity or noise around you? | | | | | |
| 12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated? | | | | | |

Advanced Psychiatric Care PC 6700 Winkler Road,Unit 4 Fort Myers, FL 33919
(239)935-5599 Phone (239)313-5614 Fax Advancedpsychcare9400@gmail.com

Patient Name:_____ Today's Date:_____

| | | | | | |
|---|---|---|---|---|---|
| 13. How often do you feel restless or fidgety? | | | | | |
| 14. How often do you have difficulty unwinding and relaxing when you have time to yourself? | | | | | |
| 15. How often do you find yourself talking too much when you are in social situations? | | | | | |
| 16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves? | | | | | |
| 17. How often do you have difficulty waiting your turn in situations when turn taking is required? | | | | | |
| 18. How often do you interrupt others when they are busy? | | | | | |

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APC

# Suboxone Contract

You are undergoing treatment for opioid dependence with Suboxone to manage cravings, withdrawal, and relapse prevention.

Opioid dependence has been defined as a long-term brain disease by the World Health Organization and the National Institute on Drug Abuse. It's a medical condition caused by changes in brain chemistry that occurs as a result of opioid use, successfully managed, but not cured, with the combination of medication and behavioral change. Therefore the following expectations apply and are required by the federal government: **EVERYONE IS REQUIRED**

1. For the duration of treatment you will be required to stay abstinent from all non-prescribed mood altering chemicals. All pain medication must be authorized through Dr. Aslam. Notify our office of all hospital visits.

    a. The medication is addictive (buprenorphine) you will be prescribed._____**initial**

2. You will comply with monthly drug tests. It will be **$25.00**, unless we bill your insurance.

Use of non- prescribed drugs will not automatically lead to discharge from the practice but if the use is not discontinued you will be referred to alternative resources and/ or a higher level of care. Our team will work with you to develop an individual treatment plan for relapse prevention.

If you continuously fail to follow recommendations and fail to demonstrate honest motivation towards achieving goals you will be discharged from the practice and taken off Suboxone.

The medication should be stored in a safe environment. The medication should be out of reach of CHILDREN and others. The medication should be locked up for your safety as well as others. Medication that has been misused or stolen will NOT be replaced. It is your responsibility! Keep the medication dry and not in a hot place where it could melt. Never store it in your car!

By signing this contract, you indicate you have read, understood and agreed to these stipulations.

Patient Signature: _____ Date:_____

Advanced Psychiatric Care PC, 6700 Winkler Road, Unit 4, Fort Myers, FL. 33919

Any question please call 239-935-5599 or email

officemanager@advancedpsychcare.com