

Consent to Disclose Substance Use Disorder Records

Sharing Information with Your Care Team in the UNM Health System (General Designation)

As part of the UNM Health System, health information of ASAP/Milagro patients is on a shared electronic medical record system. This means when you become our patient, your information is available to other care teams in the UNM Health System. In order to treat you safely, we ask you to give permission to share your information with non-Milagro/ASAP treating providers and staff in the UNM Health System. (The phrase “general designation” is the legal term which means allowing all your treating providers to receive specified information.)

Please read all the statements below. Do you have any questions about what the statements mean? It's important to ask before you sign. Your signature at the bottom shows you agree with all these statements.

I understand my substance use disorder records are protected under federal law. These laws are:

- 42 CFR (Code of Federal Regulations) part 2
- Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)
- 45 CFR (Code of Federal Regulations) parts 160 and 164

I understand my medical records cannot be released without my written consent or unless the above regulations say otherwise.

I have been given a written summary of the federal law and regulations protecting these records.

I authorize my care team at ASAP/Milagro to share the following information to other providers and clinical staff in the UNM Health System who are directly involved in my care:

- Notes about my medical conditions, including psychiatric conditions and substance use
- Psychological testing and psychotherapy notes
- Lab or medical tests and studies
- Other electronic records as medically necessary

I understand I may be denied services if I refuse to consent to share this information. I may choose to not consent to **other** kinds of information sharing, but I will not be denied services unless I refuse consent to the above.

I understand this consent is effective while I am a patient, and until I am discharged from care at ASAP/Milagro.

I understand I can take away this consent at any time and that any actions taken before I remove my consent cannot be undone.

Patient or Authorized Representative Signature

Date



HLO Approved
6/2020
812-1240

Notice of Federal Requirements about the Confidentiality of Patient Information and Substance Use Disorder

Protected Information

The privacy of substance use disorder patient records kept by this program is protected by federal law and regulations.

Generally, the program must keep your attendance in the program private. The program may not disclose (share) any information about whether you now have or have had a substance use disorder. The only time a program can do these things is if:

- you consent in writing;
- the disclosure is allowed by a court order and a subpoena;
- the disclosure is made to medical personnel in a medical emergency; or
- the disclosure is made to qualified personnel for research, audit or program evaluation.

You have the right to get a list of the people who receive your information. You can make a request in writing (within two years of the time the information is shared). You have a right to receive the list within 30 days from the date your written request is received.

Information That Is Not Protected

Federal law and regulations do not protect any information:

- related to a crime, if you commit one, on the site of this program or against personnel of the program
- about suspected child abuse or neglect (under state law this information must be reported to appropriate state or local authorities).

What to Do if the Laws are Not Followed

Violation of federal law and regulations by this program is a crime. Suspected violations may be reported to the United States Attorney in the district where the violation occurs.

To contact the United States Attorney's Office for the District of New Mexico, call (505) 346-7274 or visit their website at <https://www.justice.gov/usao-nm>.

See 42 U.S.C. § 290dd-2 for federal law and 42 C.F.R. Part 2 for federal regulations governing Confidentiality of Substance Use Disorder Patient Records.



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About Me

Your answers to these questions help us make sure we meet your needs and give the best, safest health care to all patients. Your answers will remain private. Access to this information is very restricted. Thank you!

What name do you want us to call you?

What is the sex on your original birth certificate?

- Male Female

Do you consider yourself Hispanic or Latino?

- Yes No
 Don't want to answer

What is your race? (Pick One)

- American Indian or Alaska Native
 Asian
 Black or African American
 Native Hawaiian or other Pacific Islander
 White or Anglo

In what language do you prefer to talk about your health care? (Pick One)

- English
 Spanish
 Vietnamese
 Navajo
 American Sign Language
 Other:

You have the right to a free interpreter. If needed, we'll provide one for you.

In what language do you prefer to read about your health care? (Pick One)

- English
 Spanish
 Vietnamese
 Other:
 I need help with reading

If you are American Indian/ Native American, what tribe(s) or pueblo(s)?

- Pueblo:
 Navajo
 Apache:
 Other:

What is your spiritual preference?

- Atheist
 Buddhist
 Catholic
 Christian or Protestant:

- Jehovah's Witness
 Jewish
 Latter-Day Saints/Mormon
 Muslim
 Native:
 Sikh
 Spiritual
 Other:
 No Preference

What is your relationship status?

- Single
 Legally married
 Domestic partnership/ civil union
 Partnered, living together
 Partnered, not living together
 Divorced/permanently separated
 Widowed/separated by death
 Other:

What is your current gender identity?

- Male
 Female
 Transgender Male
 Transgender Female
 Not completely male or female
 Other:
 Don't want to answer

Do you think of yourself as:

- Straight or heterosexual
 Lesbian or gay
 Bisexual
 Other:
 Don't know
 Don't want to answer

Thank you!
 If you have questions, please ask our staff.

patient label

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

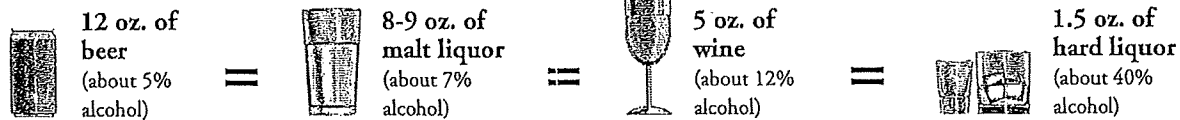
Extremely difficult

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:



Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at www.who.org.

DRUG USE QUESTIONNAIRE (DAST-20)

The following questions concern information about your potential involvement with **drugs not including alcoholic beverages** during the past 12 months. Read each statement and decide if your answer is "Yes" or "No". Then, circle the appropriate response beside the question. In the questions "drug abuse" refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs. Drugs may include (cannabis [marijuana, hash], inhalants, benzodiazepines, cocaine, methamphetamine, heroin, opioids, hallucinogens [LSD], etc.).

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past <u>12 months</u>		Circle your response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
*4.	Can you get through the week without using drugs?	Yes	No
*5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
7.	Do you ever feel bad or guilty about your drug use?	Yes	No
8.	Does your concerned significant other (e.g., spouse, partner, parent, etc.) ever complain about your involvement with drugs?	Yes	No
9.	Has drug abuse created problems between you and your concerned significant other (e.g., spouse, partner, parent, etc.)?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work / school / other because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for drug problems?	Yes	No
20.	Have you been involved in a treatment program specifically related to drug use?	Yes	No
Total Score:			

Falling Colors Enrollment Form

Name: _____		MRN: _____	
Language: _____		Gender: <input type="radio"/> MALE <input type="radio"/> FEMALE	
Ethnicity:			
<input type="radio"/> Hispanic		<input type="radio"/> Not Hispanic or Latino	
Sexual Orientation:			
<input type="radio"/> Heterosexual (Straight)		<input type="radio"/> Gay/Lesbian	
		<input type="radio"/> Other <input type="radio"/> Prefer not to answer	
Race:			
<input type="radio"/> White		<input type="radio"/> Native American or Alaskan Native, Tribal Affiliation: _____	
<input type="radio"/> Asian		<input type="radio"/> Black or African American <input type="radio"/> Other: _____	
Are you a Veteran:			
<input type="radio"/> Yes		<input type="radio"/> No	
Marital Status:			
<input type="radio"/> Never Married		<input type="radio"/> Married	
		<input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed	
Females ONLY, Are you Pregnant:			
<input type="radio"/> Yes		<input type="radio"/> No	
Living Arrangement:			
<input type="radio"/> House Owned/ House Rented		<input type="radio"/> Supportive Housing <input type="radio"/> Structured setting	
<input type="radio"/> Homeless (bus, train, vehicle, abandoned building, etc. IF Yes, For how long? _____)			
<input type="radio"/> Staying with Family or Friends			
Select highest Level of Education completed:			
<input type="radio"/> Grade 8		<input type="radio"/> Grade 9	
<input type="radio"/> Grade 10		<input type="radio"/> Grade 11	
<input type="radio"/> Grade 12			
<input type="radio"/> GED			
<input type="radio"/> _____ years of college		<input type="radio"/> Some Post Graduate Study	
<input type="radio"/> Master's degree Completed			
<input type="radio"/> Post Graduate Study		<input type="radio"/> Graduate	
<input type="radio"/> Vocational School		<input type="radio"/> Self Contained Special Ed Classes	
Are you currently enrolled in school:			
<input type="radio"/> Yes		<input type="radio"/> No	
		<input type="radio"/> Not Applicable	
Employment Status:			
<input type="radio"/> Part Time		<input type="radio"/> Full Time	
		<input type="radio"/> Unemployed <input type="radio"/> Not in Labor Force	
Source of Income:			
<input type="radio"/> Wages/Salary		<input type="radio"/> Public Assistance	
		<input type="radio"/> Not Applicable	

Falling Colors Enrollment Form

How were you referred to us:

- Individual (self referral) Alcohol/Drug abuse care provider Other Health care provider
 School Employer/Employee Assistance program Other Community Referral

Have you been Arrested in the last 30 days:

- Yes, how many times? _____ No

Is CYFD Involved:

- Yes No

Which Health Insurance(s) do you have:

- Private Insurance other than BCBS or HMO BCBS Medicare
 Medicaid HMO Other (Tricare, etc.) None

Which Substance(s) are you currently taking:

- Alcohol
- Marijuana/Hashish
- Barbiturates: Phenobarbital, Secobarbital
IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____
- Benzodiazepines: Xanax, Librium, Clorazepate, Diazepam, Flurazepam, Lorazepam, Triazolam, Halazepam, Flunitrazepam, Clorazepate
IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____
- Cocaine/Crack: Crack, other cocaine
IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____
- Hallucinogens: LSD, DMT, Mescaline
IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Falling Colors Enrollment Form

CONTINUED Which Substance(s) are you currently taking:

Heroin

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Inhalants o Aerosols, Nitrites, Gas, Glue, Solvents (paint thinner), Anesthetics-Chloroform, etc

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Methamphetamine/Speed

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Non-prescription Methadone, Suboxone

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Other Amphetamines: Bath Salts, Ecstasy, MDMA

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Other Drugs: Dilantin, Spice, Special K

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

Other Opiates and Synthetics: Codeine, Darvon, OxyContin, Demerol, Fentanyl.

IF YES, Route of Administration: Oral Smoking Inhalation Injection
 Other: _____

******FOR OFFICAL USE ONLY:**

Medicaid ID: _____

DATE of registration: _____

Other: _____