

# Glenbeigh

ARMC Healthcare System



## SUBSTANCE USE DISORDER (SUD) SINGLE CONSENT FORM

### PATIENT INFORMATION

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ MRN# \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
PHONE NUMBER \_\_\_\_\_

I authorize Glenbeigh to use and disclose information to the following:

NAME/COMPANY \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_  
PHONE \_\_\_\_\_ FAX \_\_\_\_\_

### TYPE OF INFORMATION TO BE DISCLOSED

- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> HISTORY AND PHYSICAL EXAM  | <input type="checkbox"/> PSYCHOSOCIAL ASSESSMENT | <input type="checkbox"/> ADMISSION LETTER        | <input type="checkbox"/> PROGRESS NOTES          | <input type="checkbox"/> DISCHARGE SUMMARY/ DISCHARGE PLAN |
| <input type="checkbox"/> BACK TO WORK LETTER  | <input type="checkbox"/> DRUG SCREENS            | <input type="checkbox"/> VERBAL TREATMENT UPDATE | <input type="checkbox"/> COLLECT COLLATERAL DATA | <input type="checkbox"/> OTHER _____                       |
| <input type="checkbox"/> COUNSELING NOTES (A counseling note is defined as a note analyzing the conversation in a SUD counseling session that the clinician voluntarily maintains separately from the rest of the chart.) |  |  |  |  |

### PURPOSE OF DISCLOSURE

- |  |  |                                       |                                      |
|--|--|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> ONGOING TREATMENT | <input type="checkbox"/> LEGAL PROCEEDINGS | <input type="checkbox"/> PERSONAL USE | <input type="checkbox"/> OTHER _____ |
|--|--|---------------------------------------|--------------------------------------|

DATES OF SERVICE TO RELEASE FROM: \_\_\_\_\_ TO: \_\_\_\_\_

An episode of Care is defined as a "Continued treatment at any level of care within the Glenbeigh organization without a break of service of more than 30 days"

**RIGHT TO REVOKE:** I understand that I have the right to revoke this consent at any time by providing written notice to Glenbeigh, except to the extent we have already acted in reliance on this consent.

### REVOCAION OF RELEASE OF INFORMATION

I hereby withdraw my consent for this release of information. \_\_\_\_\_  
Signature Date Time

Please submit all revocations in writing to:

Glenbeigh's Privacy Officer/Medical Records Department  
2863 State Route 45 | P.O. Box 298  
Rock Creek, OH 44084  
Email: GBInquire@glenbeigh.com | Phone: 800-234-1001

I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy laws, except as prohibited by 42 CFR Part 2. **I ACKNOWLEDGE I MAY REQUEST A COPY OF THIS SIGNED CONSENT. A SIGNED COPY WILL ALSO BE PLACED IN YOUR CHART.** I understand that I am under no obligation to sign this authorization/consent and that my treatment will not depend on such. If I have **revoked** my consent to release any further information, I authorize Glenbeigh to inform all necessary parties of such revocation.

**EXPIRATION:** This consent will expire 1 year from date written, or upon my written revocation.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

SIGNATURE OF AUTHORIZED REPRESENTATIVE \_\_\_\_\_ DATE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_