| Patient's Name | Date of Birth |
|---|---|
| _____ | ___/___/___ |

In accordance with Florida Statutes and Federal law, I, _____, hereby authorize _____ (name of facility) to release to _____ (name of facility) general information from my health record as indicated below.

_____
name of facility/individual

_____
complete address of facility/individual receiving requested information

For the purpose of: ❒ Medical Care ❒ Insurance ❒ Legal ❒ Personal ❒ Other: _____

Information to be (circle one): FORWARDED OBTAINED is as follows:

This authorization is valid to release the following (please be specific):

_____ Billing Records/Abstract for Insurance
_____ Medical Record Abstract
_____ Lab Reports
_____ Nursing History & Physical
_____ Physician Notes
_____ Physician's Orders
_____ Plan of Care
_____ Other: _____

**SPECIAL INSTRUCTIONS**

1. I understand that I have the right to refuse this authorization and that Chapters Health Palliative Care may not condition treatment, payment or eligibility for benefits on my refusal to sign this authorization. I hereby waive all rights I have to preserve the confidentiality of any information and records released pursuant to this authorization.
2. I understand that the information in my medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
3. PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. The facility, its agents, and those individuals or organizations specified are released from any and all legal liability that may arise from the release of the information and records requested. Any unauthorized re-disclosure is strictly prohibited and may no longer be protected under federal privacy rules.
4. Federal regulations may restrict any use of this information to criminally investigate or prosecute any drug/alcohol patient and may prohibit making any further disclosure of it without the specific authorization of the undersigned or as otherwise permitted by such regulations.
5. This authorization is subject to written revocation at any time, except to the extent that the facility which is to make the disclosure as already taken action in reliance on it. Written revocation of this authorization must be submitted to the Chapters Health System Department of Health Information Services. This authorization will remain in effect until such time that the purpose is accomplished for which it was given or will expire six months after the date of authorization.

_____ ___/___/___
Patient/Legal Representative Signature Date

_____ _____
Legal Representative Name *(please print)* Reason Patient Did Not Sign

_____ ___/___/___
Chapters Health Palliative Care Representative Signature Date

CHAPTERS HEALTH®
Palliative Care

# RELEASE OF INFORMATION AUTHORIZATION



**ID #:** _____

**Patient Name:** _____
*(Print)* *Last* *First*

**INFORMED CONSENT INFORMATION:** Palliative care is a medical specialty that focuses on relieving pain and symptoms associated with advanced, chronic and life-limiting illnesses. The Chapters Health Palliative Care team addresses the physical, emotional and spiritual needs of patients, and helps coordinate care and community services.

I voluntarily consent to receive palliative care services provided by Chapters Health Palliative Care. I agree these services are mutually understood to be appropriate and that I may withdraw my consent at any time. The services provided by Chapters Health Palliative Care are designed to provide pain management and symptom control associated with advanced, chronic and life-limiting illnesses. Such services/activities shall include evaluation and assessment by a team of palliative care professionals including medical staff services, nursing services and medication management. Chapters Health Palliative Care will coordinate services with physicians and other healthcare providers as needed.

By signing below, I consent to Chapters Health Palliative Care (1) providing the services identified above that meet my individual needs and (2) documenting, in its records and care plans, any medical, nursing, physical, emotional and spiritual needs, or other information necessary for Chapters Health Palliative Care to fulfill its functions and provide such services.

**ACKNOWLEDGEMENT OF RECEIPT OF THE FOLLOWING DOCUMENTS:** I acknowledge that Chapters Health Palliative Care has provided me with a copy of its Notice of Privacy Practices.

I understand I may request restrictions on Release of Information by submission in writing for approval to the Compliance Dept. at 12470 Telecom Dr., Suite 300 W., Temple Terrace, FL 33637 or via email to CHSComplianceGroup@chaptershealth.org.

**AUTHORIZATION TO RELEASE PRIVATE HEALTH INFORMATION (PHI):** I voluntarily authorize and give my permission and allow disclosure of all my PHI, including information about sensitive conditions (e.g., drug/alcohol/substance abuse, psychological/psychiatric/mental impairments, developmental disabilities, sickle cell anemia, HIV/AIDS or other communicable or sexually transmitted diseases and genetic diseases), if any, to and from Chapters Health Palliative Care and any of the following: (1) my insurance company or any authority or organization, private or governmental, including but not limited to, the Social Security Administration and its intermediary, Medicare/Tricare and Medicaid, which may be responsible for reimbursement or payment for the care and services provided; (2) any Health Information Exchanges (HIE) whereby the sharing and accessing of patient health information is electronically shared with other permitted providers; and (3) other healthcare providers involved in my medical care (including their staff members, agents and business associates) for continuity and coordination of care purposes, as permitted by law. This includes information in paper or oral form and records created before or after the date of my signature below. The authorization will remain in effect until the day I withdraw my permission.

**LIABILITY FOR PAYMENT:** I, or my personal representative, authorizes Chapters Health Palliative Care to accept an assignment of benefits and receive payment on my behalf from insurance companies and/or third party payers. I acknowledge that I will be personally responsible for all applicable deductibles, copayments, or any charges not covered by my insurance company or third party payer. I understand that services provided to me by Chapters Health Palliative Care will be billed according to the insurance information provided under:

Medicare Medicaid Commercial Insurance Private Pay

I understand that Chapters Health Palliative Care will provide notice to me and my representative of any changes to payments for which I may be responsible, as soon as possible after the changes occur, and in advance of the next scheduled clinic visit.

Patient Signature: _____ Date: ___/___/___

Patient unable to sign because: _____

Authorized Representative Signature (if any): _____ Date: ___/___/___

Authorized Representative Name (printed): _____

Representative is acting on patient's behalf as: ❒ **Guardian** ❒ **HCS** ❒ **DPOA-HC** ❒ **HC Proxy**

Chapters Palliative Care Representative Signature: _____ Date: ___/___/___

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Palliative Care

# INFORMED CONSENT/ PAYMENT LIABILITY



**ID #:** _____

**Patient Name:** _____
*(Print)* *Last* *First*

WHITE: Patient Record YELLOW: Patient

This form is part of the shared decision making between my palliative care clinician and me. It is intended to serve as an educational tool and is part of my informed consent to take these medications. My palliative care clinician and I have the shared goal of safely and effectively controlling my pain with minimal or no side effects.

❒ My palliative care clinician has recommended that I take (or continue) an opioid medication for my pain as part of a symptom management plan that my clinician and I have discussed and agreed to.

❒ My palliative care clinician has assessed my pain and other symptoms and explained why this medication is being prescribed and what other options there may be.

❒ My palliative care clinician has discussed with me non-opioid treatment options and discussed the advantages and disadvantages of those non-opioid options for treating my pain.

❒ My clinician and I have discussed how my pain affects me and have identified the following treatment goals:

- o Improve functioning at work and home
- o Improve sleep
- o Other: _____

❒ My palliative care clinician has also recommended the following non-medication treatments to assist in the treatment of my pain or shortness of breath

- o Exercise
- o Rest
- o Relaxation techniques
- o Therapies such as physical therapy or occupational therapy
- o Counseling
- o Application of heat or cold
- o Acupuncture
- o Non-opioid medications
- o Referral to another physician for assessment, radiation, a procedure or possible surgery
- o Other: _____

❒ I understand that opioid medications are generally safe if taken exactly as directed, but could have side affects (such as constipation, nausea, sleepiness, confusion, difficulty urinating, slowing or stopping breathing, among others).

❒ I also understand that opioid medications can be dangerous and lead to death or addiction if misused.

❒ I will promptly report any significant side effects to my palliative care clinician.

❒ I will take the medication exactly as prescribed, and not make any changes in how much or how often I take it, unless instructed by my palliative care clinician.

❒ I will keep the medication safe, secure and out of the reach of children.

❒ I will not drive, operate heavy equipment or dangerous tools, or participate in any dangerous sports until I know how these medications affect me and I have discussed this with my palliative care clinician.

❒ I understand that taking opioid pain medications with alcohol or street drugs is dangerous and could lead to serious injury or death

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# ADULT OPIOID USE AGREEMENT AND CONSENT – PG 1 OF 2



**ID #:** _____

**Patient Name:** _____
*(Print)* *Last* *First*

❒ I will not sell or share my medication with anyone for any reason.

❒ I will not drink alcohol when I am taking an opioid pain medication.

❒ I will not use any illegal substances.

❒ I will inform my palliative care clinician of all medications that I am taking, and will immediately let my clinician know about any new prescriptions of any kind given to me by other doctors in order to avoid any adverse drug interactions.

❒ I will sign a release form to allow my palliative care clinician to speak with any of my other treating physicians.

❒ I will inform all my other physicians about all the medications that I am taking including those prescribed by my palliative care clinician.

❒ I will not obtain a prescription for opioid medications from any other doctor with the possible exception of a medical or dental emergency. If I am prescribed opioid medications in one of those situations, I will promptly inform my palliative care clinician.

❒ I will not take any other medicines that can be addictive such as benzodiazepines (for example Klonopin, Xanax, Valium) or stimulants (for example Ritalin, amphetamine) without telling my palliative care clinician before I fill that prescription. I understand that the only exception to this is if I am given medicine for a medical or dental emergency at night or on a weekend.

❒ I will bring all of my medication bottles (with the medications inside) to all my appointments with my palliative care clinician.

❒ I agree to undergo urine testing at random to screen for controlled or illegal substances if asked by my palliative care clinician.

❒ I understand that, except in unusual circumstances, I will not be prescribed any refills on or new opioid medications unless I am seen by my palliative care clinician in the office.

❒ I will not call for refills on opioid pain medications after hours or on weekends.

❒ Except in the case of a medical or dental emergency, I will have all my pain medications filled at one pharmacy, and allow my palliative care clinician and my pharmacist to share information about my pain medications.

❒ Failure to follow this agreement could have consequences, up to and including my being dismissed from the palliative care practice.

Patient Signature: _____ Date: ___/___/___

Patient unable to sign because: _____

Authorized Representative Signature (if any): _____ Date: ___/___/___

Authorized Representative Name (printed): _____

Representative is acting on patient's behalf as: ❒ **Guardian** ❒ **HCS** ❒ **DPOA-HC** ❒ **HC Proxy**

Prescribing Clinician Signature: _____ Date: ___/___/___

Prescribing Clinician Name (printed): _____

CHAPTERS HEALTH®
Palliative Care

# ADULT OPIOID USE AGREEMENT AND CONSENT – PG 2 OF 2



**ID #:** _____

**Patient Name:** _____
*(Print)* *Last* *First*

# Talk to your health care provider about how to treat your pain. Create a safe and effective treatment plan that is right for you.

## Alternatives to Opioids: Medications

**ADVANTAGES:**

- Can control and alleviate mild to moderate pain with few side effects.
- Can reduce exposure to opioids and dependency.

**DISADVANTAGES:**

- May not be covered by insurance.
- May not be effective for severe pain.

Florida HEALTH

| NON-OPIOID MEDICATIONS | DESCRIPTIONS, ADDITIONAL ADVANTAGES & *DISADVANTAGES* |
|---|---|
| **Acetaminophen (Tylenol)** | Relieves mild–moderate pain, and treats headache, muscle aches, arthritis, backache, toothaches, colds and fevers. *Overdoses can cause liver damage.* |
| **Non-steroidal Anti-inflammatory Drugs (NSAIDs):** Aspirin, Ibuprofen (Advil, Motrin), Naproxen (Aleve, Naprosyn) | Relieve mild–moderate pain, and reduce swelling and inflammation. *Risk of stomach problems increases for people who take NSAIDs regularly. Can increase risk of bleeding.* |
| **Nerve Pain Medications:** Gabapentin (Neuraptine), Pregabalin (Lyrica) | Relieve mild–moderate nerve pain (shooting and burning pain). *Can cause drowsiness, dizziness, loss of coordination, tiredness and blurred vision.* |
| **Antidepressants:** Effexor XR, Cymbalta, Savella | Relieve mild–moderate chronic pain, nerve pain (shooting and burning pain) and headaches. *Depending on medication, side effects can include: drowsiness, dizziness, tiredness, constipation, weight loss or gain.* |
| **Medicated Creams, Foams, Gels, Lotions, Ointments, Sprays and Patches:** Anesthetics (Lidocaine), NSAIDs, Muscle Relaxers, Capsaicin, Compound Topicals | Can be safer to relieve mild-moderate pain because medication is applied where the pain is. Anesthetics relieve nerve pain (shooting and burning pain) by numbing an area; NSAIDs relieve the pain of osteoarthritis, sprains, strains and overuse injuries; muscle relaxers reduce pain by causing muscles to become less tense or stiff; and capsaicin relieves musculoskeletal and neuropathic pain. Compounded topicals prepared by a pharmacist can be customized to meet a patient's specific needs. *Skin irritation is the most common side effect. Capsaicin can cause warmth, stinging or burning on the skin.* |
| **Interventional Pain Management** | Includes anesthetic or steroid injections around nerves, tendons, joints or muscles; spinal cord stimulation; drug delivery systems; or permanent or temporary nerve blocks. Medicates specific areas of the body. Can provide short-term and long-term relief from pain. *Certain medical conditions and allergies can cause complications.* |
| **Non-opioid Anesthesia** | Opioids can be replaced with safer medications that block pain during and after surgery. A health care provider or an anesthesiologist can provide options and discuss side effects. |

Florida Department of Health, Office of Communications, 09-20-19

# Alternatives to Opioids: Therapies

**ADVANTAGES:**

- **Can control and alleviate mild to moderate pain with few side effects.**
- **Can reduce exposure to opioids and dependency.**
- **Treatment targets the area of pain—not systemic.**
- **Providers are licensed and regulated by the State of Florida.* (appsmqa.doh.state.fl.us/MQASearchServices)**

**DISADVANTAGES:**

- **May not be covered by insurance.**
- **Relief from pain may not be immediate.**
- **May not be effective for severe pain.**

**Sources: American College of Surgeons, Centers for Disease Control and Prevention, National Institutes of Health, the Food and Drug Administration, Harvard Health and Wexner Medical Center (Ohio State University)**

| THERAPIES | DESCRIPTIONS, ADDITIONAL ADVANTAGES & *DISADVANTAGES* |
|---|---|
| **Self-care** | **Cold and heat:** Ice relieves pain and reduces inflammation and swelling of intense injuries; heat reduces muscle pain and stiffness. Can provide short-term and long-term relief from pain. *Too much heat can increase swelling and inflammation.*<br><br>**Exercise and movement:** Regular exercise and physical activity can relieve pain. Simply walking has benefits. Mind-body practices like yoga and tai chi incorporate breath control, meditation and movements to stretch and strengthen muscles. *Maintaining daily exercise and overcoming barriers to exercise can be a challenge.* |
| **Complementary Therapies** | **Acupuncture:** Acupuncturists* insert thin needles into the body to stimulate specific points to relieve pain and promote healing. Can help ease some types of chronic pain: low-back, neck and knee pain, and osteoarthritis pain. Can reduce the frequency of tension headaches. *Bleeding, bruising and soreness may occur at insertion sites.*<br><br>**Chiropractic:** Chiropractic physicians* practice a hands-on approach to treat pain including manual, mechanical, electrical and natural methods, and nutrition guidance. Can help with pain management and improve general health. *Aching or soreness in the spinal joints or muscles sometimes happens—usually within the first few hours after treatment.*<br><br>**Osteopathic Manipulative Treatment (OMT):** Osteopathic physicians* use OMT—a hands-on technique applied to muscles, joints and other tissues—to treat pain. Clinically-proven to relieve low-back pain. *Soreness or stiffness in the first few days after treatment is possible.*<br><br>**Massage therapy:** Massage therapists* manually manipulate muscle, connective tissue, tendons and ligaments. Can relieve pain by relaxing painful muscles, tendons and joints. Can relieve stress and anxiety—possibly slowing pain messages to and from the brain. *At certain points during a massage, there may be some discomfort—especially during deep tissue massage.*<br><br>**Transcutaneous electrical nerve stimulation (TENS):** TENS is the application of electrical current through electrodes placed on the skin with varying frequencies. Studies have shown that TENS is effective for a variety of painful conditions. The intensity of TENS is described as a strong but comfortable sensation. *Allergic reactions to adhesive pads are possible.* |
| **Rehabilitation Therapies** | **Occupational therapy:** Occupational therapists* treat pain through the therapeutic use of everyday activities. Can relieve pain associated with dressing, bathing, eating and working. Therapy includes activities that increase coordination, balance, flexibility and range of motion. *Therapy interventions and recommendations will not help if the patient does not practice as instructed.*<br><br>**Physical therapy:** Physical therapists* treat pain by restoring, enhancing and maintaining physical and functional abilities. *Therapy interventions and recommendations will not help if the patient does not practice as instructed.* |
| **Behavioral and Mental Health Therapies** | **Psychiatrists*, clinical social workers*, marriage and family therapists* and mental health counselors*** provide therapies that identify and treat mental disorders or substance abuse problems that may be roadblocks to pain management. *When used to manage pain, these therapies can take time.* |