Name:	Date of Birth:	(internal) EMR ID:

ACCOMMODATING HEALTHCARE SOLUTIONS CONSENTING DOCUMENT

CONSENT TO TESTING, TREATMENT, CARE COORDINATION, CARE OUTREACH for any condition, including VIRAL HEPATITIS, HIV, and SEXUALLY TRANSMITTED INFECTIONS: I have been given information about the services Accommodating Healthcare Solutions provides and consent to these services.

GRIEVANCE POLICY: I understand that, if for any reason I have a concern or grievance with the services provided by a member of Accommodating Healthcare Solutions, I can contact Kevin Moore at 215-510-5199.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES:
I have been offered the opportunity to receive a printed copy of the Notice of Privacy Practices, dated August 27, 2024 of Accommodating Healthcare Solutions. I have been informed that the Notice of Privacy Practices is also available at https://ahsopc.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL SUBSTANCE USE DISORDER PATIENT RECORDS: I authorize Accommodating Healthcare Solutions to release and obtain information to/from the following:

1. All treatment providers past, current, and future; for the **purpose** of Case Coordination; **amount and kind**: all or _____;
   until 10 years from today's date or _____;
2. All third-party insurers, such as Medicaid, Medicare, HMOs, MCOs, etc; for the **purpose** of reimbursement and/or population health management; **amount and kind**: all or _____;
   until end of coverage and all claims are settled, or _____.

- I fully understand the above statements as they apply to me.
- I consent to the release of records/information for the purpose stated above.
- I understand that I may revoke this consent at any time, except to the extent information has already been released in reliance on this form.
- I acknowledge I am entitled to a complete listing of disclosures including date, entity, and brief description of the patient identifying information disclosed.

By signing below, I am acknowledging that I have had the above information explained to me and I agree and consent to receive treatment at Accommodating Healthcare Solutions.

Signature_____ Date:_____

Witness signature & name (printed):_____

NOTICE PROHIBITING RE-DISCLOSURE OF HIV-RELATED INFORMATION
This information will be disclosed from records protected by Pennsylvania law. Pennsylvania law prohibits further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose.

NOTICE PROHIBITING RE-DISCLOSURE OF SUBSTANCE USE DISORDER INFORMATION
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.