Patient Label (Name, DOB, etc.)

Consent to Services Agreement

WHAT ARE THE RECOVERY SOLUTIONS SERVICES AVAILABLE TO ME? Axial Healthcare, through your health plan, offers to help guide you in your journey of recovery so that you understand the options you have access to including:

- transition services
- peer recovery support
- access to a recovery referral community
- other community based resources

CONSENT TO TREATMENT:

- I voluntarily agree to receive services provided by Axial Healthcare, Inc. ("Axial") and its team members.
- I understand Axial is providing the services through my health plan.
- I received a copy of Axial's Notice of Privacy Practices for Recovery Solutions.
- I understand that Axial needs to receive medical information about my diagnostic procedures, examinations, and treatment from my healthcare providers.
- I understand photographs, digital, and/or other images may be recorded for treatment purposes.
- I understand that no promises, warranties or guarantees have been made to me about the Recovery Solutions.
- I allow the release of my medical information when needed for treatment, payment, healthcare operations, and for state/federal agencies.

I understand that this Consent to Services is active while services are provided to me by Axial unless I tell Axial in writing that I no longer want to be a part of the Recovery Solutions program.

WHAT TYPE OF MEDICAL INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at your medical providers. This includes information concerning mental illness (except for psychotherapy notes), use of alcohol, drugs, communicable diseases (such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS")), laboratory test results, medical history, treatment progress, or any other such related information.

For further information or questions on this consent form, please contact us at 1-888-417-4304.

My signature below shows that I understand and agree with the above information and give consent for Axial's Recovery Solutions.

______________________ Date

______________________ Signature of Patient/Other legally authorized person

______________________ Printed Name/Relationship to Patient

Contacting You

We want your permission to talk with you. May we phone, email, or send a text message to you? [ ] yes   [ ] no

May we leave a voice message at your home or on your cell phone? [ ] yes   [ ] no

May we tell any of your family members or other people about your treatment information or the services (including sharing PHI)?

[ ] yes   [ ] no

Who may we tell?

Approved family members: ____

Approved individual: ____

Approved individual: ____

May we tell your doctors, treatment provider(s), community based resources, or other care team members about your treatment information or the services (including sharing PHI)? [ ] yes   [ ] no

Authorization to Release Confidential Information

Section 1: What information am I agreeing to share?
I give my permission to my doctor(s), pharmacist(s), their service providers, or other healthcare and/or treatment facilities ("Providers") to share and/or get information about me:

- Substance Use Disorder (SUD) treatment records maintained by my providers (including, but not limited to, medications and dosages, lab test results, clinic visits, diagnostic information, discharge summary etc.)

and

- Claims data related to Substance Use Disorder (SUD) treatment, which includes a summary of my diagnoses and services received.

Section 2: Who may share my Substance Use Disorder (SUD) information?
Please select one or both of the following options:

Option 1: "I give permission for all of my past, current, or future treating providers to share my substance use disorder treatment information."

Option 2: "I give permission for these specific individual(s) or organization(s) to share my substance use disorder treatment information."

Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

Option 3: "I select both Option 1 and Option 2"

Section 3: Who may receive my Substance Use Disorder (SUD) information?
Please select one or both of the following options:

Option 1: "I give permission for all of my past, current, or future treating providers to receive my substance use disorder treatment information."

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Name of the individual(s) and/or healthcare organization(s) that I have (or had) a treating provider relationship:	Enter their contact information:			
	Phone	City	State	ZIP Code

Option 3: "I select both Option 1 and Option 2"

Section 4: How to stop the sharing of your information:
I understand that I can take back or cancel my permission to share my information at any time. When I take back or cancel my permission, I understand that going forward, my information will no longer be shared.

I understand that any information that may have already been shared before I cancelled my permission cannot be taken back.

To take back or cancel your permission to share your information, please contact either:

Axial Healthcare, Inc.
Attention: Compliance
209 10th Ave S #332
Nashville, TN 37203

OR

compliance@axialhealthcare.com

Date ____________

Signature of Patient/Other legally authorized person ____________

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Printed Name/Relationship to Patient