



Welcome to the Denver Adult Down Syndrome Clinic!

We are glad to meet with you. We are located in the Potomac Street Health Care Clinic, which is operated by MCPN, Metro Community Providers Network. Thus, your paperwork will refer to the Denver Adult Down Syndrome Clinic (DADSC) and MCPN. You will now be considered an MCPN patient under the umbrella of the Denver Adult Down Syndrome Clinic.

A Medical and Social History questionnaire is enclosed in this package. Also included are various forms we must keep on file for legal purposes. A Release of Information form is included for you to obtain records from your physician, if needed. Please mail/fax to your physician, or, bring the records with you. It can sometimes take several weeks to receive these records. All questions refer to the adolescent or adult with Down syndrome. If you do not understand a question, leave it blank and we can discuss it on the visit day.

Please fill these forms out and mail to us prior to your visit. You may fax the information to us at 303-360-3713.

If possible, please bring:

- Immunization Records
- Previous thyroid blood test results
- Previous echocardiogram reports
- Any information relating to a specific problem you would like us to address
- Current Medicare, Medicaid or other insurance information
- Legal guardianship papers, if you have them

Your visit to the clinic will last about two hours and includes medical and social evaluations. A familiar staff or family member must accompany each patient to assist in answering questions. Your visit to the DADSC includes a psychosocial assessment with our psychotherapist, who is experienced in working with individuals with developmental disabilities and is knowledgeable of resources and opportunities for these individuals and those who support them. You can expect to discuss lifestyle, behaviors, recent events and any concerns you may have with the psychotherapist. A complete assessment report will be mailed to you in 4-6 weeks which will include the medical report from the physical examination.

We look forward to meeting you. Please contact us if you have questions before your appointment.

Sincerely,

The Staffs of the Denver Adult Down Syndrome Clinic and MCPN

Denver Adult Down Syndrome Clinic

700 Potomac Street, Suite A Aurora, CO 80011

303-360-3712 **MCPN**; 303-762-6545 **DADSC**; 303-360-3713 **FAX**; 303-360-3716 **TDD**

Intake Forms

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Patient Registration Form**

Patient Information:

First Name and Middle Initial: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ CO: _____

Home Phone: _____ Contact Phone: _____

Social Security Number: _____ Email Address: _____

Date of Birth: _____ Age _____ Gender: _____

Family/Guardian/Service Provider:

Parent or Legal Guardian Name: _____

Relation to Patient: _____ Phone: _____

Address: _____

Service Provider/Agency: _____

Address: _____

Contact Person: _____ Phone: _____

Insurance Information:

Name of Insurance Plan: _____ ID Number: _____

Subscriber's Name: _____ Employer: _____

Referral Information:

Primary Care Physician: _____ Address: _____

Referring Physician: _____ Address: _____

Please Bring A Letter of Referral with You.

Financial Agreement, Consent and Release

I hereby authorize my insurance benefits to be paid directly to MCPN and acknowledge full responsibility for the unpaid balance, and to pay for such services, if not covered by insurance. I also authorize MCPN to release relevant information to the insurance company.

Signature: _____
Parent or Legal Guardian

Date: _____

Denver Adult Down Syndrome Clinic Metro Community Provider Network Health Questionnaire

All Questions Refer to the Person with Down syndrome (DS).

Name _____ Date of Birth: _____ Age: _____

Person filling out the form/relationship: _____

Do you have any health worries about the person with DS? Please write in the space below or on another sheet of paper, if necessary.

Recent Changes:

Regular Routine:

Have there been any recent changes in his or her day? Yes _____ No _____

If so, please describe: _____

Behavior, feelings and memory:

- Has the person with DS had trouble remembering things or been forgetful? Yes _____ No _____
- Had any change in his/her usual behavior? Yes _____ No _____
- Had any change in his/her interest in life/activities? Yes _____ No _____
- Seemed sad or withdrawn? Yes _____ No _____
- Are you concerned about how the person with DS is acting or feeling? Yes _____ No _____

Physical Problems:

Eating, drinking and weight

- Is the person with DS having trouble eating food or drinking liquids? Yes _____ No _____
- Having trouble swallowing solid foods or drinks? Yes _____ No _____
- Having trouble choking/gagging on solid foods or drinks? Yes _____ No _____
- Does the person with DS have any special dietary needs? Yes _____ No _____
- Has the person with DS lost weight? Yes _____ No _____
- How much weight loss or gain? _____ Over what length of time? _____

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Intake Forms

Bathroom:

- Is the person with DS having difficulty with bowel movements (BM) or constipation? Yes_____ No_____
- Does the person have accidents with urine or BMs? Yes_____ No_____

Walking:

- Does the person with DS have difficulty walking? Yes_____ No_____
- Does he/she fall frequently? Yes_____ No_____

Endocrine:

- Does the person with DS have a thyroid problem? Yes_____ No_____
- Has he/she ever been diagnosed with diabetes? Yes_____ No_____
- Has he/she been drinking more liquids lately? Yes_____ No_____
- Recently been urinating more? Yes_____ No_____

Brain:

- Can the person learn to do new things? Yes_____ No_____
- Stopped being able to do things he/she used to do? Yes_____ No_____
- Has the person ever had seizures, fits, spasms? Yes_____ No_____
- _____

Sleep:

- Does the person with DS seem more tired? Yes_____ No_____
- Any problems sleeping or snoring? Yes_____ No_____
- Does he/she stop breathing for a short while when asleep? Yes_____ No_____
- _____

Skin:

- Does the person with DS have dry skin? Yes_____ No_____
- Any other skin problems? Yes_____ No_____
- Products you use for skin problems: _____

Eyes, Ears, Nose, Mouth and Sinuses:

- Does the person wear glasses or contacts? Yes_____ No_____
- Any problems with seeing? Yes_____ No_____
- Does the person with DS have difficulty hearing? Yes_____ No_____
- Is there a problem with ear infections? Wax build-up? Yes_____ No_____
- Does the person have a frequent runny nose? Yes_____ No_____
- Does he/she have sinus problems? Yes_____ No_____

Mouth:

- Does the person with DS have teeth or gum problems? Yes_____ No_____
- Does he/she wear dentures? Yes_____ No_____
- Has she or he had other dental work? Yes_____ No_____
- Brush his/her teeth daily? Yes_____ No_____
- Floss regularly? Yes_____ No_____
- Does he/she see a dentist regularly? Yes_____ No_____

Lung:

- Does the person with DS get pneumonia often? Yes_____ No_____
- Have a persistent cough? Yes_____ No_____
- Get frequent bronchitis? Yes_____ No_____

Genital:

For women:
 Age periods began_____ How often she get her period_____ How long does it last_____
 Is she sexually active? _____ Is birth control needed? _____ Is she on birth control? _____
 Has she ever been pregnant? _____ Has she had a Pap smear? _____ Date of last PAP_____
 Has her PAP ever been abnormal? _____ Has she had a mammogram? _____ Date: _____
 Has she ever had an abnormal mammogram? _____ Does she practice safe sex? _____

For Men:
 Is the man with DS sexually active? _____ Does he practice safe sex? _____ Does he
 have a hernia? _____ Does he have undescended testicle? _____

Medications:

Please bring bottles of all medications, over the counter medicines, or natural products the person with DS is taking to show the doctor.

Allergies:

Has the person with DS ever been told he/she is allergic to food, animals, medicine or things outdoors? If yes, please list: Yes_____ No_____

Medical History:

For new patients, please answer the questions below. **For returning patients,** please answer the questions with any new information since the last complete physical at our clinic.

- Has the person with DS been admitted to a hospital or had an operation? Yes_____ No_____

Date_____ Hospital_____

Reason_____

- Has another health professional said this person has a medical problem? Yes_____ No_____
- If yes, what are the medical problems reported?

- Has the person with DS had any heart problems? Yes_____ No_____

If yes, what type? _____

- Was the person told to take an anti-biotic when going to the dentist? Yes_____ No_____
 - Has the person ever had neck x-rays? Yes_____ No_____
 - Was there any problem found on the x-rays? Yes_____ No_____
 - Has the person been tested for celiac disease (sprue or wheat intolerance?) Yes_____ No_____
- If so, what were the results of the tests? _____

Immunizations:

Please complete the following or bring the person’s immunization records.

- Has the person with DS had the three Hepatitis B vaccinations? Yes_____ No_____
- When was the last DPT or tetanus shot? _____
- Has he/she had chicken pox? Yes_____ No_____
- Has she/he had the chicken pox vaccine? Yes_____ No_____
- Does he/she get the flu shot each fall? Yes_____ No_____
- Has she/he had the pneumonia vaccine? Yes_____ No_____
- Has she had the HPV vaccine? Yes_____ No_____

Health Care Providers:

Please list the names of any other people or hospitals from whom the person with DS receives health care.

Name:

Specialty or Type of Provider:

_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History:

Please check the box for everyone in the family of the person with DS who has had any of the following health problems:

Conditions in the Family	Mother	Father	Sibling	Other
Down syndrome	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
High Cholesterol	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Dementia or Alzheimer’s disease	_____	_____	_____	_____
Heart Disease	_____	_____	_____	_____

Denver Adult Down Syndrome Clinic

Intake Forms

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Seizures	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Cancer, Leukemia	_____	_____	_____	_____
Depression/Mental Illness	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Habits:

- Does the person with DS smoke? Yes_____ No_____
 If yes, how much? _____ If quit, when? _____
- Does the person with DS drink alcohol? Yes_____ No_____
 If yes, how much? _____ If quit, when? _____
- Does he/she use recreational/illegal drugs? Yes_____ No_____
 If yes, how much? _____ If quit, when? _____

Exercise:

- Does the person with DS participate in regular exercise or times when he/she plays sports, walks swims or runs? Yes_____ No_____

If yes, what types, how long and how often?

Occupation/School:

- Does the person with DS attend school, a day program or have job? Yes_____ No_____

What is the name of the school or job site or day program? _____

If no, did the person do this in the past/where?

Residence:

- Where does the person with DS live?
 - Family home _____
 - Own home _____
 - Group home _____
 - If in a group home, how many people live there? _____
 - Is the group home free standing or in a large complex/campus environment? _____

Social Information:

1. Parents

Names	Ages	Occupations
<hr/>		
<hr/>		
<hr/>		
<hr/>		

2. Siblings

Names	Ages	Marital Status	Living in Household?
<hr/>			
<hr/>			
<hr/>			
<hr/>			

3. Community Access Providers/Case Managers/Support Staff

Names	Employed by	Addresses
<hr/>		
<hr/>		
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4. Please discuss any current safety concerns:

5. Which safety issues concern you the most? Check all that apply.

Sex _____ Money _____ Abuse _____
Con Artist _____ Other _____

Do safety issues ever interfere with the freedom or independence of the person with DS to access his/her community?

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Consent for Clinical Diagnosis and Treatment**

Patient's Name: _____

Social Security Number: _____ **Date:** _____

I, _____, do hereby give consent to the clinical staff of the MCPN/DADSC clinic to examine, treat and counsel me. I understand that there are certain hazards and risks connected with all forms of treatment and my consent is given with this knowledge.

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

Adult Down Syndrome Clinic Metro Community Provider Network Bill of Patients' Rights and Responsibilities

You have the right to:

- Receive services that necessary for your care without regard to race, color, creed, national origin, age, sex, sexual preference, marital status, number of pregnancies, type of contraceptive, disability or political affiliation.
- Be treated with courtesy, dignity and respect.
- Know the names and functions of the doctors, nurse practitioners, nurses and other people caring for you.
- Be told by your caregivers what your condition and diagnosis is, what treatment they recommend, how they expect your condition to change, and what follow-up care is necessary.
- Know the reason for various tests and treatments given to you and the names of the persons giving them to you.
- Know the benefits, risks, and discomforts of any procedure or treatment recommended to you.
- Refuse treatment and to be informed of the medical or other consequences of your refusal.
- Be given an estimate of the charges for any medical procedures that you might undergo during your treatment. Patients are cautioned that actual charges may differ from those estimated, due to any changes in diagnosis, unanticipated complications, changes in insurance information, etc.
- A full explanation of all papers MCPN and the DADSC will ask you to sign.
- Receive information necessary to give informed consent prior to the start of any procedure and/or treatment, except for emergency situations.
- Refuse to sign a consent form.
- Cross out any part of the consent form that you do not want applied to your care.
- Change your mind before undergoing a procedure for which you have given your consent.
- Refuse to participate in research projects.
- Have access to your MCPN/DADSC medical records. This does not include records received from other providers, such as referrals and old records.
- Expect that records related to your care remain confidential. Information in these records can be released only under the following circumstances:
 - You authorize the release.
 - There is immediate danger.
 - A duly authorized court order is issued.
- Arrange to meet with another provider for a second opinion.
- Arrange to change providers, clinics or hospitals.
- Expect that the staff will respect your personal privacy to the fullest extent allowed by the care you need. You may also request a chaperon for any exam.
- Upon request, examine and receive explanation of your bill.
- Express spiritual and cultural beliefs that do not harm others or interfere with their care.
- Give us ideas on how to improve our services.
- Be informed of the clinic's complaint and formal grievance procedure.
- File a complaint or formal grievance and have it acknowledged and resolved in a timely and orderly fashion.
- Know the facility's rules and regulations that apply to you as a patient.

Denver Adult Down Syndrome Clinic Metro Community Provider Network Bill of Patients' Rights and Responsibilities

You have the responsibility to:

- Treat others with courtesy, dignity and respect.
- Consider the rights of other patients and staff and to help control noise.
- Keep your appointments and be on time. If you cancel or change your appointment, we request 24 hour notice.
- Give, upon request, necessary records for registration, billing, ability to pay and authority to consent.
- Bring insurance or Medicaid/Medicare card to each clinic visit.
- Give truthful and complete information about your present symptoms, past illnesses, other times you have sought medical care or been hospitalized, medicine you are taking, and other questions about your health.
- Take part in your care and follow through with referrals.
- Accept the results if you refuse treatment or do not follow the caregiver's instructions.
- Ask questions if you do not understand papers you are asked to sign or information given to you.
- Tell your caregiver when you are not pleased with your care.
- Pay your co-pay or self-pay at the time of check-in for each visit.
- Assure that your bill is paid.
- Keep your personal belongings in a safe place.

Lack of regard for any of the following responsibilities can result in dismissal from the MCPN practice. Do not....

- Miss more than three appointments. This applies to financial screening appointments as well as medical appointments.
- Commit physical violence on the premises of MCPN.
- Threaten or verbally attack other patients or staff.
- Commit illegal activities on the MCPN premises.
- Destroy MCPN or patient property.
- Use obscenities on the MCPN premises.

I have received a copy of the Patient Bill of Rights and Responsibilities and have had a chance to read it and ask questions.

Patient Signature

Date

Denver Adult Down Syndrome Clinic Metro Community Provider Network Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

1. Understanding your Health Information

Each time you visit our community health center, a record of your visit is created. This record usually contains your name and other information that may identify you, your symptoms, examination and test results, diagnoses, treatment, plan for future health care, and financial information. This record is sometimes referred to as “your medical record” or “medical chart.” This record allows:

- Doctors, nurses and other health professionals to plan your treatment;
- Our community health center to obtain payment for services we provide to you, such as from health plans, Medicaid, or you; and
- Our community health center to measure the quality of care provided to you.

As we have in the past, we are committed to keeping your health information confidential. We will not use or give to others your health information without your written permission, except as stated in this Notice.

2. How We Will Use and Give Out Your Health Information

a. Treatment, Payment and Health Care Operations

We will use and give out your health information to provide you with health care treatments, to get paid for our services, and to help us operate our community health center. For example:

- We will give your health information to health care professionals not on our staff, such as other doctors and hospital staff, who help care for you;
- We may send a bill to your health insurance plan or to you, and;
- Our community health center may use your medical record to review our performance and make sure you receive quality health care.

b. Other uses and Disclosures Allowed or Required by Law

We may use or give out your health information for the following purposes under limited circumstances:

- To people who are involved in your care or who help pay for your care, such as your family, your close personal friends, or any other person chosen by you, to notify them of your location, general health, and to assist you in your health care (such as to pick up medicine or help with follow up care);
- To government agencies that oversee our community health center (such as license and certification inspectors);
- To government agencies that have the right to receive and collect health information (such as to control disease outbreaks);
- When we are ordered by a judge;
- To workers’ compensation programs when your health problem is from a work related injury;

- When law enforcement requests information (such as to prevent danger or injury);
- To coroners and funeral directors to allow them to carry out their duties;
- To organ donor agencies (subject to applicable laws);
- For research studies that meet all privacy law requirements (such as research to stop a disease);
- To avoid a serious threat to the health or safety of others;
- To contact you about new treatments or medicines that may help you;
- To business associates of the community health center that help us perform required tasks, such as our accountants, computer consultants, and billing companies (only if the business associates agree in writing to keep your health information confidential as required by law); and
- For any other purpose required or allowed by law.

c. Other Uses and Disclosures Requiring Your Written Permission

Except as stated above, we will use or give out your health information only after getting your written permission on an Authorization form. You may revoke your authorization at any time by notifying us in writing that you wish to do so.

3. **Your Rights Regarding Your Health Information**

Subject to certain legal limits, you have rights regarding the use and disclosure of your health information, including the rights to:

- Request limits on uses of your health information
- Receive confidential communications of your health information
- Inspect and copy your health information
- Request a record of how we have used and given out your health information
- Obtain a copy of this Notice of Privacy Practices

4. **Questions, Concerns and Changes to this Notice**

If you have any questions or want to talk about any of the information in this Notice of Privacy Practices, please contact MCPN/DADSC at 3701 S. Broadway, Englewood, CO 80110, Attn: Monty Moore, HIPPA Officer, 303-761-1977. All complaints must be submitted in writing. We will not retaliate against you for filing a complaint.

We may change our Notice of Privacy Practices in the future. Such changes will apply to your health information that we created or received before the effective date of the change. We will notify you of any changes to our Notice of Privacy Practices by posting the changed notice at our community health center and on our website.

I, _____, acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of MCPN/DADSC on this _____ day of _____, 20____. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices.

Signature of Patient

Signature of Staff

Printed Name of Patient

Printed Name of Staff

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Consent to Use Protected Health Information**

This document is in compliance with HIPPA Privacy regulations and is intended for use only by MCPN and the DADSC for the patient listed below. This consent for MCPN/DADSC to use and/or disclose Protected Health Information for the patient listed below is good during the time period indicated here.

Beginning Date: ____/____/____

to Ending Date: ____/____/____

Patient Name

Medical Record Number

Patient Date of Birth

Address

City

State

Zip Code

By signing this consent, MCPN/DADSC may use or disclose protected health information for the patient listed above to carry out treatment, payment, or health care operations. Prior to signing this consent form, please review the MCPN/DADSC Notice of Privacy Practices. MCPN/DADSC reserves the right to change the Notice of Privacy Practices document without notice. You may obtain a current copy by asking for a copy at the front desk.

Under HIPPA Privacy Rules, the following rights and requirements apply:

- The right to request restrictions on uses and disclosures of protected health information for treatment, payment and health care operations purposes. (MCPN/DADSC are not required to agree to requests on uses and disclosures, but if MCPN/DADSC do agree to the request, the restriction is binding on MCPN/DADSC. All restrictions must be submitted in writing.)
- The right to revoke this consent in writing, except to the extent where MCPN/DADSC has taken action in reliance on the consent (used of released information prior to the consent being revoked). To revoke this consent, see signature line at the bottom of the form.

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Consent to Use Protected Health Information**

I authorize the following people to pick up my Protected Health Information.

Indicate name(s) in the above space ONLY if you would like to have another person have the ability to pick up protected health information for you.)

You may contact me by phone to leave common lab results.

Patient Signature

Patient Name Printed

Date

Office Use Only

Witness:

Verification of signer by valid ID. Power of Attorney (must include copy)

Witness Signature

Witness Name Printed

Date

To void this consent, the patient must sign and date this document. Signature must be witnessed by MCPN/DADSC staff.

Patient Name Printed: _____
Patient Signature: _____ Date: ____/____/____
MCPN Staff Signature: _____ Date: ____/____/____

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Authorization to Release/Request Medical Information**

I, _____ Date of Birth: ____/____/____
First Name Middle Initial Last Name

authorize MCPN/DADSC to obtain information from and share medical information with:

Name of Doctor/Facility: _____ Street: _____

City/State/Zip Code: _____ Phone: _____ Fax: _____

This may include:

- Admission History, Including Diagnosis and Treatment
- Lab Studies
- Physical Exam
- Educational Material
- Other

List Specific Purpose for which Information is to be Released:

- Assessment Continuity of Care Service Planning Other

I understand that I may revoke this authorization to release/request information at any time by giving written notice to MCPN/DADSC. Without such revocation, this authorization shall expire on ____/____/____. Or, if left blank, one year from the date of my signature. I release MCPN/DADSC from all liability for releasing such information.

I understand that information to be released may include information regarding the following conditions:

- Drug Abuse Psychiatric Conditions Sexual Abuse

If the information to be released pertains to the diagnosis and treatment of alcoholism and or drug abuse, I understand that the confidentiality of this information is protected by Federal law 42, CFR, part 2.

Signature of Client/Parent/Legal Guardian

Relationship to Patient

Date

Witness

Notice to whom this information is given: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific written consent of the person to whom it pertains.

I hereby revoke this Authorization to Release/Request for Information.

Patient: _____ Witness: _____
Date: _____ Date: _____

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Verification of Lawful Presence**

AFFIDAVIT

I, _____, swear or affirm under penalty of perjury under the laws of the State of Colorado that: (Check one)

- I am a citizen of the United States of America, or
- I am a permanent resident of the United States of America, or
- I am lawfully present in the United States of America pursuant to Federal law.

I understand that this sworn statement is required by the law because I have applied for a public benefit. I understand that state law requires me to provide proof that I am lawfully present in the United States prior to receipt of this public benefit. I further acknowledge that making a false, fictitious, or fraudulent statement or representation in this sworn affidavit is punishable under the criminal laws of Colorado as perjury in the second degree under Colorado Revised Statute 18-8-503 and it shall constitute a separate criminal offense each time a public benefit is fraudulently received.

Signature

Date

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Report Distribution Schedule**

Patient _____

Date: _____

Three to four weeks after a full clinic visit to the MCPN/DADSC, a written summary is sent that includes a report of all the evaluations and recommendations. The signature below authorized us to send the report. The list beneath informs us of whom you want the report to be sent.

Patient's Signature, if self guardian: _____

Or:

Signature of Guardian or Empowered Staff: _____

I hereby authorize and request copies of the report to be sent to:

Family/Patient: Name and Address

Service Agency/Residential Facility: Name and Address

Primary Physician: Name and Address

**Denver Adult Down Syndrome Clinic
Metro Community Provider Network
Report Distribution Schedule**

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Date: _____

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