Amerigroup
An Anthem Company

Patient Label (Name, DOB, etc.)

Wayspring

Consent to Services Agreement

WHAT ARE THE RECOVERY SOLUTIONS SERVICES AVAILABLE TO ME? Wayspring, 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.

CONSENT TO TREATMENT:

- I voluntarily agree to receive services provided by Wayspring and its team members.
- I understand Wayspring is providing the services through my health plan.
- I received a copy of Wayspring's Notice of Privacy Practices for Recovery Solutions.
- I understand that Wayspring needs to receive medical information about my diagnostic procedures, examinations, and treatment from myhealthcare 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 Wayspring unless I tell Wayspring in writing that I no longer want tobe 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.

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

_____ _____

Date Signature of Patient/Other legally authorized person

_____

Printed Name/Relationship to Patient

Waysprings

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 condition 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) or other care team members about your condition 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."
- ☐ Option 2: "I give permission for these specific individual(s) or organization(s) to receive 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 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:

Wayspring
Attention: Compliance
209 10th Ave S #350
Nashville, TN 37203

OR

compliance@wayspring.com

_____
Date

_____
Signature of Patient/Other legally authorized person

_____
Printed Name/Relationship to Patient

Do you need free help with this letter?
If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that's available.

Spanish: **Español**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-600-4441 (TRS: 711).

Kurdish: **ک وردی**

ئاگاداری: ئەگەر بە زمانی کوردی هەیە، خزمەتگوزارییەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-800-600-4441 (TRS: 711) بکە.

Arabic: **ةيبرعلا**

وظقحلم: اذا متتكلا ةللغا ةيبرعلا اتمدخ ةعالمسا وئةللغا رةفومتك انجام. ائصل مقبر: 1-800-600-4441 (TRS: 711) مقر فتاه صملا و ملبكا

Chinese: **繁體中文**

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-600-4441 (TRS: 711)。

Vietnamese: **Tiếng Việt**

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-600-4441 (TRS: 711).

Korean: **한국어**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-600-4441 (TRS: 711) 번으로 전화해 주십시오.

French: **Français**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-600-4441 (TRS: 711).

Amharic: አማርኛ

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-600-4441 (መስማት ለተሳናቸው:TRS: 711).

Gujarati: **ગજુ ર ાતી**

સચુ ના: જો તમે ગજુ ર ાતી બો લતા હો, તો ન:શલુ ક ભા ષા સહાય સે વા ઓ તમારા મા ટે ઉપલબ્ધ છે. ફો ન કરો 1-800-600-4441 (TRS: 711).

Laotian: **ພາສາລາວ**

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-600-4441 (TRS: 711).

German: **Deutsch**

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-600-4441 (TRS: 711).

Tagalog: **Tagalog**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-600-4441 (TRS: 711).

Hindi: **ह दि ं ी**

ध्यान द: यदद आप ह दि ं ी ब ोलत ह त ो आपक लए मुफ्त म भ ाष सहायत सेवाउपलब्ध ह। 1-800-600-4441 (TRS: 711) पर क ॉल कर।

Serbo-Croatian: **Srpsko-hrvatski**

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-600-4441 (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Russian:	**Русский**
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-600-4441 (телетайп: TRS: 711).	
Nepali:	**नेपाली**
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको ननम्तत भाषा सहायता सेवाहरू ननिःशुल्क रूपमा उपलब्ध छ । फोन गनुहुस 1-800-600-4441 (दिदिवाई: TRS: 711).	
Persian:	**ف ار سی**
توجه: اگر به زبان نارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-600-4441 (TRS: 711) تماس بگیرید.	

- Do you need help talking with us or reading what we send you?
- Do you have a disability and need help getting care or taking part in one of our programs or services?
- Or do you have more questions about your health care?

Call us for free at 1-800-600-4441. We can connect you with the free help or service you need. (For TRS call: 711.)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birth place, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birth place, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

TennCare Office of Civil Rights Compliance 310 Great Circle Road, 3W Nashville, TN 37243 Email: HCFA.Fairtreatment@tn.gov Phone: 855-857-1673 (TRS 711) You can get a complaint form online at: https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf	Amerigroup Nondiscrimination Coordinator 22 Century Blvd., Suite 220 Nashville, TN 37214 Email: tn.nondiscrimination@amerigroup.com Phone: 1-800-600-4441 (TRS 711) Fax: 1-866-796-4532	U.S. Department of Health & Human Services Office for Civil Rights 200 Independence Ave. SW, Rm 509F, HHH Bldg Washington, DC 20201 Phone: 800-368-1019 TDD: 800-537-7697 You can get a complaint form online at: http://www.hhs.gov/ocr/office/file/index.html Or you can file a complaint online at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf