

Modified Mini Screen (MMS)

Client Name: _____

OASAS ID _____

Weeks since admission _____

Interviewer _____

Today's Date _____

Supervisor Initials (Optional) _____

SECTION A

1. Have you been consistently depressed or down, most of the day, nearly every day for the past 2 weeks?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Have you felt sad, low or depressed most of the time for the last two years?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	YES <input type="checkbox"/>	NO <input type="checkbox"/>
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6	_____	

SECTION B

<p>7. Note this question is in 2 parts.</p> <p>a. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way?</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>b. If yes, did these intense feelings get to be their worst within 10 minutes?</p> <p style="text-align: center;"><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>Interviewer: If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO.</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>
<p>8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Being in a crowd <input type="checkbox"/> Standing in a line <input type="checkbox"/> Being alone away from home or alone at home <input type="checkbox"/> Crossing a bridge <input type="checkbox"/> Traveling in a bus, train or car 	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>
<p>9. Have you worried excessively or been anxious about several things over the past six months?</p> <p>Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>
<p>10. Are these worries present most days?</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>
<p>11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated?</p>	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>
<p>12. In the past month, have you been bothered by thoughts, impulses or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Were you afraid that you would act on some impulse that would be really shocking? <input type="checkbox"/> Did you worry a lot about being dirty, contaminated or having germs? <input type="checkbox"/> Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? <input type="checkbox"/> Were you obsessed with sexual thoughts, images or impulses? <input type="checkbox"/> Did you hoard or collect a lot of things? <input type="checkbox"/> Did you have religious practice obsessions? 	<p>YES</p> <p><input type="checkbox"/></p>	<p>NO</p> <p><input type="checkbox"/></p>

SECTION B (CONTINUED)

<p>13. In the past month, did you do something repeatedly without being about the resist doing it?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Washing or cleaning excessively <input type="checkbox"/> Counting or checking things over and over <input type="checkbox"/> Repeating, collecting or arranging things <input type="checkbox"/> Other superstitious rituals 	<p align="center">YES</p> <p align="center"><input type="checkbox"/></p>	<p align="center">NO</p> <p align="center"><input type="checkbox"/></p>
<p>14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Serious accidents <input type="checkbox"/> Sexual or physical assault <input type="checkbox"/> Terrorist attack <input type="checkbox"/> Being held hostage <input type="checkbox"/> Kidnapping <input type="checkbox"/> Fire <input type="checkbox"/> Discovering a body <input type="checkbox"/> Sudden death of someone close to you <input type="checkbox"/> War <input type="checkbox"/> Natural disaster 	<p align="center">YES</p> <p align="center"><input type="checkbox"/></p>	<p align="center">NO</p> <p align="center"><input type="checkbox"/></p>
<p>15. Have you re-experienced the awful event in a distressing way in the past month?</p> <p>Examples include:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dreams <input type="checkbox"/> Intense recollections <input type="checkbox"/> Flashbacks <input type="checkbox"/> Physical reactions 	<p align="center">YES</p> <p align="center"><input type="checkbox"/></p>	<p align="center">NO</p> <p align="center"><input type="checkbox"/></p>
<p>PLEASE TOTAL THE NUMBER OF “YES” RESPONSES TO QUESTIONS 7-15</p>		



Denis G. Patterson, DO
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Board Certified Physical Medicine & Rehabilitation

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tele 775.284.8650
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Client Name: _____

DOB: _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

1. Have you ever felt that you ought to cut down on your drinking or drug use?
 YES NO
2. Have people ever annoyed you by criticizing your drinking or drug use?
 YES NO
3. Have you ever felt bad or guilty about your drinking or drug use?
 YES NO
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or get rid of a hangover?
 YES NO

In the past 12 months:

1. Use of additional drugs other than those required for medical reasons: YES NO
2. Abusing more than one drug at a time: YES NO
3. Being unable to stop using drugs when you want to: YES NO
4. Having blackouts or flashbacks as a result of drug use: YES NO
5. Feeling bad or guilty about your drug use: YES NO
6. Your spouse or parents complaining about your involvement with drugs:
 YES NO
7. Neglecting your family because of your use of drugs: YES NO
8. Engaging in illegal activities in order to obtain drugs: YES NO
9. Experiencing withdrawal symptoms (agitation, sick) when you stop taking drugs:
 YES NO
10. Having medical problems as a result of your drug use (memory loss, hepatitis, convulsions, bleeding, etc.): YES NO
11. Have a past history of addiction: YES NO

Please indicate substance of choice: _____



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NEVADA ADVANCED PAIN SPECIALISTS

CONSENT TO TREATMENT

The undersigned, being of 18 years of age, does hereby consent to any mental health and/or addiction examination, diagnosis or treatment, which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician any physician or other provider licensed in the State of Nevada and working for Nevada Advanced Pain Specialists, and their agents and employees, whether such diagnosis or treatment is rendered at the office of said physician or at a hospital.

This authorization shall remain effective until _____, 20____, unless sooner revoked in writing.

Dated

Patient

Print Name: _____



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Nevada Advanced Pain Specialists Behavioral Health Cancellation and Rescheduling Policy

To gain the most benefit from our office and to ensure that other clients receive the highest level of care, it is essential to keep all your scheduled appointments.

If you are more than 15 minutes late for an appointment, you may not be seen that day. We try to keep to our schedule and you being late will affect the next client.

We understand the need at times to cancel your appointment. If you must cancel your appointment, please give us at least 24 hours' notice. There are other patients requiring our care and your appointment can be given to someone else with enough notice.

If you fail to attend your appointment without calling or giving less than 24 hours' of notice cancellation, you will be charged \$25. This is NOT covered by your insurance and this amount will have to be paid before scheduling another appointment.

If you miss (no show) more than **2** appointments or reschedule more than **2** initial evaluation appointments, you may not be seen again by behavioral health and other treatment referrals might be considered to re-evaluate your motivations for healing.

Thank you for helping us provide the best care possible.

Acknowledgement of Cancellation Policy

I have read and understand the Nevada Advanced Pain Specialists Behavioral Health Cancellation Policy.

Signature

Date

NEVADA ADVANCED PAIN SPECIALISTS

PRIVACY PRACTICES NOTICE

The Effective Date of This Notice is _____

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.

PRIVACY PRACTICES NOTICE

This page describes the type of information Nevada Advanced Pain Specialists (“NAPS”) will gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information, except when the release is required by law, or permitted by law without your authorization.

If the practices described in this notice meet your expectations, there is nothing you need to do. If you prefer additional limitations on the use of your medical information, you may request them following the procedure below.

If you have any questions about this notice, please contact our Privacy Officer at the address below.

The regulations also require that we make a good faith effort to obtain your written acknowledgement that you have received this Notice. This is why you will be asked to sign this form at the end.

Who Will Follow This Notice

This notice describes practices of all of the persons and entities in NAPS regarding the use of your medical information and that of:

- Any health care professional employed by or contracted with NAPS who is authorized to enter information into your hospital chart or medical record.

- All departments and units of NAPS you may visit.

- All NAPS employees, staff and other personnel who may need access to your information.

- All entities, sites and locations of NAPS that follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or health care operations purposes as described in this notice.

Our Pledge Regarding Medical Information

We understand that medical information about you and your health is personal. Protecting medical information about you is important. We create a record of the care and services you receive. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by NAPS, whether made by health care professionals or other personnel.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- a. keep confidential any medical information that concerns your condition or treatment, how your care is paid for and demographic information, if such information can be used to identify you;
- b. give you this notice of our policies, procedures and information privacy practices with respect to medical information about you; and
- c. follow the terms of the notice that is currently in effect.

Nevada Law

In addition to federal law, Nevada law places more stringent limitations on the disclosure and use of mental health information, genetic information, communicable disease information and blood and urine tests. Other federal regulations place more stringent requirements on drug and alcohol abuse information. We shall comply with those more stringent restrictions.

How We May Use and Disclose Medical Information about You

The following categories describe different ways that we may use and disclose medical information. For each category of uses or disclosures we will try to give some examples. Not every use or disclosure in a category will be listed.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian if you have diabetes so that we can arrange for appropriate meals. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside NAPS who may be involved in your medical care or that provide services that are part of your care.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, your insurance may need to know about treatment you received so they will pay us or reimburse you for the treatment. We may also use and disclose medical information about you to obtain prior approval or to determine whether your insurance will cover the treatment, or to undertake other tasks related to seeking payment for services provided. We may also disclose medical information to another health care provider who is or has been involved in your treatment, so that that provider may seek payment for services rendered.

For Health Care Operations Purposes. We may use and disclose medical information about you for health care operations purposes. This is necessary to make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you, or to otherwise manage and operate NAPS effectively. We may also disclose information to doctors, nurses, technicians, training doctors, medical students, and other NAPS personnel for review and learning purposes. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.

Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. We may release medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave NAPS. Otherwise, we will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to the person(s) threatened and/or someone able to help prevent the threat.

Special Situations

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of

recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the overall health care system, the conduct of government programs, and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

Law Enforcement. We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

Protective Services for the President, National Security and Intelligence Activities. We may release medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations, or for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official where the release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Your Rights Regarding Medical Information About You.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer at the address below. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. In some circumstances, if you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the NAPS will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (i) Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (ii) Is not part of the “designated record set” kept by the NAPS; (iii) Is not part of the information which you would be permitted to inspect and copy; or (iv) Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. This accounting will not include many routine disclosures; including those made to you or pursuant to your authorization, those made for treatment, payment and operations purposes as discussed above, those made to the facility directory as discussed above, those made for national security and intelligence purposes and those made to correctional institutions and law enforcement in compliance with law.

To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request additional restrictions or limitations on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

However, we are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our Privacy Officer at the address below. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply

Right to Opt Out of Electronic Transmission. Under Nevada law, you have the right to “opt-out” of electronic transmissions of your medical information. However, NAPS may not be able to provide care for you if you choose to exercise this right.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. If complying with your request entails additional expense over our usual means of communication, we may ask that you reimburse us for those expenses.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

To obtain a paper copy of this notice, please request one in writing from our Privacy Officer at the address below.

Changes To This Notice

We reserve the right to change our policies and practices concerning the privacy of your medical information and this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will always post a copy of the current notice in the patient waiting rooms. The notice will contain the effective date on the first page.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with NAPS or with the Secretary of the Department of Health and Human Services. To file a complaint with NAPS, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer

The Provider's Privacy Officer is: *{Name, Mailing Address, Telephone, Fax, e-mail, other means of correspondence}*

Acknowledgement

I hereby acknowledge that I have received a copy of the Privacy Practices Notice.

Signature: _____ Date: _____

Print Name: _____

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Privacy Practices Notice.

Date: _____

Name of Patient: _____

Reason for refusal/failure: _____

Signature of NAPS Employee: _____

File Signed Copy of this Page with Patient's Record

NEVADA ADVANCED PAIN SPECIALISTS

AUTHORIZATION FOR THE RELEASE

OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of Protected Health Information (“PHI”) pursuant to 45 CFR Parts 160 and 164 and certain Nevada laws.

1. The undersigned authorizes Nevada Advanced Pain Specialists (“NAPS”) to release the following information: (describe in a “specific and meaningful fashion”)

2. The information may be disclosed by employees or business associates of NAPS.

3. The information may be disclosed to: (insert name or other specific identification of the persons or entities to which the disclosure will be made)

I understand and agree that the information to be disclosed includes the following types of information which are protected under Nevada law:

3.1 blood, breath or urine test results

3.2 communicable disease information, including information about sexually transmitted disease, including HIV and AIDS.

3.3 information about mental health treatment I have sought and/or received.

3.4 information about drug and/or alcohol abuse treatment I have sought and/or received.

3.5 psychotherapy notes (See **Note** at end of form.)

4. The disclosure may be made for the following purpose (describe specifically. If disclosure it at patient’s request, “At request of patient” will suffice. If more than one purpose, describe each.)

5. This authorization will expire on (date) _____, or when (describe occurrence) _____.

6. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once the information is disclosed, it may no longer be protected by federal privacy law. I understand that I may revoke this authorization only in a writing sent by certified mail to NAPS at 10715 Double R Blvd., Reno, NV 89521, Attn: Privacy Officer. The revocation will be effective only upon receipt, except (1) to the extent NAPS has acted in reliance on the

authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use to the protected health information to lawfully contest a claim. Further information on the right to revoke may be provided from time to time in the NAPS's Notice of Privacy Practices.

I understand that treatment by NAPS is not conditioned on my signing this authorization, although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physicals, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization requested prior to enrollment, or where payment is conditioned on an authorization to use PHI to determine payment.

Date: _____

Signed by : _____

Print Patient's Name: _____

If person signing is other than patient, state authority under which signature is made: _____

NOTE: If psychotherapy notes are to be disclosed, a separate copy of this authorization form must be used. An authorization for the release of psychotherapy notes cannot be combined with an authorization to release other protected health information.

The patient must be given a copy of this authorization.