



AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED INFORMATION

I, (print name) _____ Date of Birth: _____ authorize the Siouxland Paramedics Community Paramedics Team, and the following entities:

- **Siouxland Mental Health Center**
- **Unity Point Health St. Lukes**
- **Mercy Medical Center**
- **Siouxland Community Health**
- **Woodbury County Mental Health Services**
- **Siouxland District Health Center**
- **Family Healthcare of Siouxland**
- **Siouxland Paramedics**
- **Family Medicine**
- **PACE**
- **Siouxland Center**
- **Other:** _____

To communicate with and disclose to one another the following written or verbal information:

Please check all the appropriate information:

- Initial and subsequent evaluation of my service needs by the Community Paramedics and its members
- Current and past Mental Health Treatment Programs, including dates
- Current and past Chemical Dependency Treatment Programs, including dates
- Current and past Emergency Department Visits, including dates and cost
- Past and/or present protected Mental Health Information
- Past and/or present Substance Use Information
- Past and/or present Health Information
- Other: Information needed to obtain housing, food, and other resources
- Other: _____

The purpose of this disclosure release is to coordinate care or services related to assessment, referral, medical, substance use, mental health, vocation, transportation, shelter \ housing.

This authorization will automatically expire (1) year from the date of signature, except as specified:_____. No express revocation shall be needed to terminate my consent, I understand that this consent is voluntary and I may revoke this consent at any time by sending written notice to Siouxland Paramedics Community Paramedics, 1110 Dace Ave, Sioux City, IA 51101. I understand that any information released prior to the revocation may be used for the purposes listed above, and does not constitute a breach of my rights to confidentiality, I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and once the information is disclosed, it may no longer be protected by federal privacy regulations. I understand that I may review the disclosed information by contacting the recipient named or Siouxland Paramedics Community Paramedics.

Mental Health Information is protected by federal and state law, Chapter 228 of the Iowa Code and federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 CGT Part 2 cannot be disclosed without my written consent. Unauthorized disclosure may result in civil damages and criminal penalties.

Client Signature

Date

Guardian Signature\Relationship

Date

New Patient Information

Date of Consultation		Name of Doctor	
Referred by		Case type	
Details of injury or illness, including date, location and other details			
Details of any treatment or first aid already administered			
Patient registration details			
Name		SS Number	
Address			
City		State	ZIP
Mobile Phone		Home phone	Work Phone
Email			
Notes & Comments			
Instructions			
<input type="checkbox"/>	Pre-visit instructions and directions provided		
<input type="checkbox"/>	Applicable records and reports acquired		
<input type="checkbox"/>	Appointment date and time confirmed		
<input type="checkbox"/>	Insurance pre-authorization completed (if required)		

Insurance Details					
Insured's name		DOB			
Relationship		Since (Date)			
Employer		Phone			
Address				Supervisor	
City		State		Zip	
Primary Insurance Company				Note	
Address				Phone	
City		State		Zip	
Contact		Title		Phone	
Notes					
Secondary Insurance				Phone	
Address				Insured's ID	
City		State		Zip	
Contact		Title		Phone	
Notes					

DOCTOR VISIT PREPARATION FORM

Doctor's Name: _____ Hospital Name: _____

Appt. Date: _____ Address: _____

Appt Time: _____

I scheduled this appointment because: _____

- Questions:
1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____
 9. _____
 10. _____

- Symptoms:
1. _____
 2. _____
 3. _____
 4. _____
 5. _____
 6. _____
 7. _____
 8. _____

Appointment Sheet

Date:

	Patient Name	Patient Name	Patient Name
8:00 AM			
:15			
:30			
:45			
9:00 AM			
:15			
:30			
:45			
10:00 AM			
:15			
:30			
:45			
11:00 AM			
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:45			
12:00 PM			
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1:00 PM			
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:30			
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2:00 PM			
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:30			
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3:00 PM			
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:45			
4:00 PM			
:15			
:30			
:45			
5:00 PM			
:15			
:30			
:45			

Blood Glucose Testing Record

Name: _____

Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						
Date		Morning	Lunch time	Dinner	Bedtime	Physical Activity
						
						

Mood Tracker

Name: _____ Month: _____ Year: _____

Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
Elevated	Severe																															
	Moderate																															
	Mild																															
Normal	Normal																															
	Mild																															
	Moderate																															
Depressed	Severe																															
	Anxiety																															
	Irritability																															
Weight																																
Sleep duration																																
Medications :																																