

**OTP Health Homes
Consent to Receive/Resume Health Home Services**

Please read all the information on this form before you sign it.

By signing this form, you agree to receive Health Home services from _____.
This means that your opioid treatment provider will begin to give you additional services designed to help you better manage your health. This may include assisting with scheduling appointments with other providers, offering information about your physical health conditions, following up when you are seen in a hospital, or connecting you with other resources that can help improve your well-being.

While participating in a Health Home will help make sure you get the services you need, you will still have a primary counselor who will provide counseling related to your addiction(s), even if you do not sign this form or do not want to receive Health Home services.

Your health information is private and cannot be given to other people without following Rhode Island and US laws and rules it cannot be given to anyone who is not involved in your care and/or to whom you have not granted consent for release of information.

Signatures

I AGREE to receive Health Home services from _____'s Health Home. I understand that my consent lasts until I take back my consent, which can be done by signing a Withdrawal of Consent Form.

Name of Member or Client's Legal Representative (print) Original Signature _____ Date

Name of OTP Health Home Case Manger (print) Original Signature _____ Date