

FOUNTAIN CENTERS

A Mayo Clinic Health System program for substance abuse and addiction

July 13, 2016

Kelsey Sikkink/CMG HR Designee
3707 Commercial Drive SW
Rochester, MN 55902

RE: Jeffrey Pachicano
DOB: 10/28/1991

Dear Kelsey,

This letter is to inform you that Jeffrey Pachicano completed a chemical use assessment here at Fountain Centers in Rochester, Minnesota on 7/11/2016. Jeffrey was sent a letter with recommendations and referral resources. Based on the data collected, the following recommendations have been made:

1. Abstain from all mood-altering chemicals, including alcohol, unless prescribed and monitored by a licensed physician.
2. Complete intensive outpatient treatment (IOP) and follow all recommendations. ←
3. Submit for an updated mental health evaluation and follow all recommendations.
4. Remain a law-abiding citizen.

If you have any questions, please feel free to contact our office at 507-252-0818.

Respectfully,

Mariah Knutson LSW

Mariah Knutson, LSW
Chemical Dependency Counselor
Fountain Centers of Rochester
507-252-0818

Albert Lea	Fairmont	Fairbault	Jackson	Mankato	Owatonna	Rochester	Waseca
408 W. Fountain St. Albert Lea, MN 56007 507-377-6411	828 N. North Ave. Fairmont, MN 56031 507-238-4382	2301 Fourth St. NW Fairbault, MN 55021 507-334-6413	308 W. Ashley St. Jackson, MN 56143 507-847-3148	1400 Madison Ave. #326 Mankato, MN 56001 507-625-3372	134 Southview St. Owatonna, MN 55060 507-451-0511	4122 18th Ave. NW Rochester, MN 55901 507-252-0818	505 S. State St. #6 Waseca, MN 56093 507-835-4342

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Authorization for Release of Information

Blank

Patient Information

Patient Name (First, Middle, Last) <i>Jeffrey Pachicano</i>		Medical Record Number	Birth Date (Month, DD, YYYY) <i>10/28/1991</i>
Address (Street) <i>507 22nd St. NW</i>		Phone Number <i>605-923-1104</i>	
City <i>Stewartville</i>	State <i>MN</i>	ZIP Code <i>55974</i>	

authorize **FOUNTAIN CENTERS, 4122 18TH AVENUE NW, ROCHESTER, MN 55901**
to disclose to and receive information from:

Name of Individual & Organization Name if Applicable <i>Kelsey Sikkink / HR Designee - CMG</i>		
Address (Street) <i>3707 Commercial Drive SW</i>		Phone Number <i>923-4955</i>
City <i>Rochester</i>	State <i>MN</i>	ZIP Code <i>55902</i>

The following information relates to my treatment for chemical dependency. Fax: *214-4904*

<input type="checkbox"/> Treatment/Discharge Summary	<input type="checkbox"/> Multidisciplinary Progress Reports/Notes
<input checked="" type="checkbox"/> Assessment/Evaluation	<input type="checkbox"/> Mental Health Reports/Notes
<input type="checkbox"/> Progress Notes	<input type="checkbox"/> History and Physical Exam
<input checked="" type="checkbox"/> Lab Results	<input type="checkbox"/> Family Questionnaire
<input checked="" type="checkbox"/> Treatment Plans	<input type="checkbox"/> Family Participation Invitation
<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> X-Ray Report(s)

COPY

The information is needed for the following purpose(s): *to coordinate care*

Dated needed by: _____

Patient Restrictions on Methods for Disclosure:

I understand that communication of the items to be obtained or disclosed can occur:

<input checked="" type="checkbox"/> Verbally	<input checked="" type="checkbox"/> Pick up	<input checked="" type="checkbox"/> In-person conference	<input checked="" type="checkbox"/> Mailed medical/correspondence
<input checked="" type="checkbox"/> Faxed medical/correspondence	<input checked="" type="checkbox"/> Written questionnaire	<input checked="" type="checkbox"/> E-mailed medical/correspondence	

- I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.), and that in any event this consent expires automatically in one year from the date I sign it or upon specified date or event: _____ Revocation must be made in writing to: Mayo Clinic Health System, Release of Information Dept., 404 Fountain St., Albert Lea, MN 56007
- I understand that Federal confidentiality regulations (42 CFR Part 2) prohibit re-disclosure of information from alcohol and drug abuse patient records. However, HIPAA requires Fountain Centers to notify me of the potential that information disclosed pursuant to this authorization might be re-disclosed by the recipient and is no longer protected by HIPAA rules.
- I understand that Fountain Centers will not condition treatment, payment, enrollment or eligibility for benefits on whether I sign the authorization.

Date <i>7-11-16</i>	Signature of Patient <i>Jeffrey Pachicano</i>
Sent	Signature of Witness <i>Melvin A. LSW</i>
By	Signature of Parent/Guardian When Necessary and Relationship to Patient

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Fax

4122 18th Ave NW
Rochester, MN 55901

To: Kelsey Sikkink Date: 7/13/16
 Company: CMG HR Fax: 216-4904
 No. of Pages (including cover sheet): 3 Phone: _____

From: Mariah Knutson, LSW Fax: 507-252-0027
 Phone: 507-252-0818

- Discharge Summary
- Assessment
- Multidisciplinary Review
- Continuing Care Plan
- ROI
- _____

Message:

This faxed information is intended only for the use of the individual or entity to which it is addressed and contains information that is **confidential**. Furthermore, this information may be protected by Federal law relating to confidentiality (42 CFR Part 2) prohibiting any further disclosure. If the reader of this message is not the intended recipient or the employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any review, dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone and destroy the original message. Thank you.