Conmed Healthcare Management, Inc.

Pre-book Medical Questionnaire

Instructions for Obtaining Medical Information prior to incarceration

Overview

The Harford County Detention Center will make every reasonable effort to assure continuity of care during your period of incarceration. In order to facilitate that continuity of care the facility is providing you with the Pre-intake Medical Questionnaire for your completion. It is important that all provided information is complete and accurate. If you have a serious medical condition it is extremely important that the health care providers at the Detention Center be able to confirm your condition, medications and treatments, and where necessary communicate with your health care providers.

The process is as follows

1. Obtain the Pre-intake Medical Questionnaire. This is available from the Courts, Office of the Public Defender or the Harford County Sheriff's Office website.

2. Bring the fully completed and signed Pre-book Medical Questionnaire to the Harford County Detention Center when you return your pre-book packets.

3. Make sure that you have answered all questions and listed all currently prescribed medications. Medications will be continued only if validated by and ordered by the Harford County Detention Center Medical Staff.

Conmed Healthcare Management, Inc. **Pre-book Medical Questionnaire**	Printed Inmate Name (Last, First, MI):	
The following information will need to be provided to assure continuity of medical care	Date of birth:	Confinement Date:

Attending Physicians, Psychiatrists and Specialists

Name	Address	Telephone Number
1.		
2.		
3.		
4.		

Current Medication

Medication Name	Dose	Frequency	Medication Name	Dose	Frequency
1.			3.		
2.			4.		

Pharmacy

Pharmacy Name:	Address:	Telephone No:

Allergies (including food, chemicals and medications)

1.	3.
2.	4.

Current Medical Problems

Type	Duration	Severity	Treating Physician
1.			
2.			
3.			
4.			

Hospitalization (past five years)

Date	Reason	Hospital Location	Date	Reason	Hospital Location
1.			3.		
2.			4.		

Medical and Physical Disabilities

1.	3.
2.	4.

Medical Devices (check all that apply)

☐Splint ☐Cast ☐Sutures ☐Cane ☐Wheelchair ☐Oxygen ☐CPAP ☐Other (specify):

Suicide Attempt

Have you ever attempted suicide: ☐ Yes ☐ No	How:	When:

Habitual Alcohol and/or Drug Use

Alcohol/Drug Type	Frequency	Amount	Last Use	Alcohol/Drug Type	Frequency	Amount	Last Use
1.				3.			
2.				4.			

Current Health Insurance Plan

Insurance Company Name:	Address:	Policy No:

The below signed individual authorizes the release of his/her medical information to the Harford County Detention Center Medical Department

Inmate Signature:	Date:

DO NOT WRITE BELOW THIS LINE

Reviewing Medical Staff Member Signature:	Title:	Date:	Time:

Conmed Healthcare Management, Inc.
Authorization for Release of Confidential Information

Inmate Name (Last, First, MI):	Date of Birth:	Inmate ID Number:
Social Security No:	Covering Records for Period of (Dates): to ☐ Any and all previous treatment at your facility	

I, do hereby authorize _____ or the Detention Facility to release/receive my confidential health information (medical, dental, psychiatric and substance abuse) including dates, history of illness, diagnostic and therapeutic treatment for the above-named patient for the purpose of clarifying diagnosis, formulate a treatment plan and aftercare. The medical records to be released may contain healthcare information pertaining to medical, dental, psychiatric and substance abuse diagnosis and treatment. In addition, I authorize disclosure of health care records received from other providers.

Information to be released:

☐	Complete Health Record	☐	Dental Treatment History
☐	Admission Summary Report	☐	Discharge Summary Report
☐	Operative Summary Report	☐	X-ray Reports
☐	Consultations/Special Report Studies	☐	Laboratory Reports
☐	Immunization History	☐	Psychiatric Summary Reports
☐	Drug Treatment and Counseling Reports	☐	Psychological Testing
☐	History and Physical Examination	☐	Social Work Summary
☐	Day Treatment Records	☐	Other Records:_____

Information to be Released To

Facility:	Clinician Name:	Title:	Telephone No:
Harford County Detention Center	Akinlawon Ayeni	M.D.	410-638-3140 Ext: 2268

Address:	City:	State:	Zip Code:
1030 Rockspring Road	Bel Air	Maryland	21014

Purpose of Disclosure: Inmate under physician's care and requires follow up treatment

This authorization will expire one (1) year from the authorizing date indicated below unless the specific expiration condition is hereby named: _____. The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this authorization for Release of Confidential Information and authorizing the disclosure is voluntary. I need not sign this form in order to assure treatment. I understand I may inspect the information to be used or disclosed as provided in CFR 186.524.

I, the undersigned have read the above and authorize the staff of the disclosing facility named to disclose such information as herein described. I understand that this authorization may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results and/or AIDS information. I understand that disclosure of health information to a party other than the one designated above is forbidden without additional authorization on my part. I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient unless the health information is protected under federal confidentiality rules 42 CFR Part 2. This facility is released and discharged from any liability and the undersigned will hold the facility, its employees, officers, and Conmed Healthcare Management, Inc., its employees, and officers harmless for complying with this "Authorization for Release of Confidential Information".

The information requested is recognized as confidential and will be used only to ensure prompt and appropriate treatment for this named inmate

Inmate Signature:		Date:	
Witness Signature:	Title:	Date:	Time:

Prohibition on Re-disclosure: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.