RJF

White County Sheriff's Dept

Medical Questions and Answers

Inmate Name:	Lynch, Jason Matthew	Date of Birth:	10/07/1982
SS Number:	430-69-8542	Intake Date:	6/10/2024
Booking Number:	24-B01797	Jacket #:	651548

Have you ever been exposed to anyone with TB (Tuberculosis)? HIV	No
Do you have any communicable diseases? (HIV, Hepatitis, Tuberculosis)	Yes
Have you ever been diagnosed and treated for any mental health condition?	No
Are you pregnant?	No
Do you take any prescription medication at this time?	Yes
Do you have any diagnosed food or drug allergies?	No

Do you take any narcotic, illegal drugs, or drink alcohol daily?

YES

If so, what and how much?

AA TO MUCH

vodka
weed
Fentanyl

Kaitlyn Zadow

Inmate Signature **Witness Signature**

Name: Jason Matthew Lynch **Questioned By: Dakota Phillips**

Jason M Lynch

No withdraw symptoms meds for HIV

Printed: 6/10/2024 9:45:58 AM

TKH 0044

Turn+Key HEALTH

General Consent for Care and Treatment

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at_ White County Detention Center _____(Facility). The consent will remain fully effective until it is revoked in writing or you are released from custody. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan about the purpose, potential risks, and benefits of any test or treatment ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request health care providers, or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Jason M Lynch **Signature**	6.15.24 **Date**
Jason Lynch **Printed** Name	
Kathryn Ladd **Printed** Name of Witness	UPJ Job Title
Kathryn Ladd **Signature of Witness**	6-15-24 **Date**

REVISED 12/16/20

TurnKey
HEALTH

AUTHORIZATION FOR DISCLOSURE AND RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: Jaun Lynch **ID#/DOB:** 10-7-82 **Facility:** White County

I hereby authorize the use or disclosure of the Protected Health Information (PHI) described below to be provided to or obtained by the following (please provide complete address):

Name of Facility or Person to receive PHI:
White County Detention Center
Address: 1400 E. Booth Road
Phone no.: 501-278-8050
Fax no.: 501-278-8058

Name of Facility or Person to Release PHI:
Address:
Phone no.:
Fax no.:

The type of information to be disclosed:

Evaluations_____
Diagnosis_____
Treatment Plan _____
X-ray reports _____
Medical/Hospital Records_____
Psychological Test Results _____
Medical Test Results _____
Lab results_____
Medications ____
Mental Health Record Summary_____
Psychotherapy Notes_____
Domestic Violence Information_____
Sexual Assault Information_____
Pregnancy Test Results _____

The purpose of such disclosure:

Ongoing Treatment_____ Medical Care_____ Consultation_____
Evaluation_____ Transfer_____ Coordination of Care_____

The designated information about me____may_____may not be transmitted by fax, electronic mail or other electronic filetransfer mechanisms. The above designated person____may____may not discuss by telephone the content of the information released.

This consent is in effect until release from custody. I understand that I may revoke this authorization, in writing, at any time unless action based on it has already taken place.

I hereby release all parties stated herewith from any liability resulting from the release of this information. I agree that a photocopy of this release shall be as valid as the original.

I understand that the information authorized for release may include records related to mental health, or drug, substance, or alcohol abuse. I also, understand that my communications in therapy are protected under federal and state confidentiality regulations and cannot be disclosed without my written authorization. The information provided by a client during therapy sessions is legally confidential in the case of licensed clinical social workers, except as provided in **section 12.43.218 CRS** and except for certain legal exceptions. In general, these exceptions pertain to matters of danger to self or others, and to assault or neglect of children.

I further understand that the potential exists for re-disclosure of my private mental health information, and that it may no longer be protected under the HIPAA privacy regulations.

I understand that information I have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the U.S. Department of Health, disclosure among health care providers or disclosure for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the U.S. Department of Health or by law.

This is to certify that I have given consent freely and voluntarily, and that the benefits and disadvantages of releasing the information, if known, have been explained to me.

Signature of Patient: Jaun W Lynch Date: 6-15-24

Signature of Parent/Guardian: _____ Date: _____

Witness Signature: Kathy Fedde Date: 6-15-24

FEDERAL REGULATIONS PROHIBIT THE RECIPIENT OF THIS INFORMATION FROM MAKING ANY FURTHER DISCLOSURES OF THIS INFORMATION.

Revised 12/16/20