MARYLAND TB PATIENT/PROVIDER AGREEMENT

Patient Name (print) _____DOB _____Record # _____
Last First Middle mm/ dd/ yyyy

I know that:

- I have suspected or confirmed tuberculosis (TB).
- TB can be spread to other people by coughing, speaking, or singing.
- TB treatment involves taking several medicines for a minimum of several months to 2 years.
- My physician must report my TB disease to the health department, according to state and Federal law.
- The health department is responsible to treat my TB disease and to prevent infection of those close to me.
- The health department can take legal action if I do not follow my TB treatment plan.

Patient Responsibilities: I will:

- Keep my appointments with the health department TB program to obtain my TB medical care.
- Cooperate with tests (sputum, chest x-ray, laboratory and others.) related to my TB treatment.
- Take my TB medicine when told to take it, including DOT (directly observed therapy) appointments.
- Call the health department right away if I don't feel well.
- Tell health department staff complete and truthful information about past or current illnesses, pregnancies or any other medicines I am taking, including over-the-counter medicines and herbal supplements.
- Tell the health department as soon as possible if I cannot keep any appointment and set up a new appointment as soon as possible.
- Tell the health department about anyone I may have exposed to my TB (this information will be treated as confidential to the extent possible).
- Tell the health department about any changes in my address, phone number(s) or emergency contact information.

Provider Responsibilities: The _____ County Health Department will:

- Clearly explain TB disease and its risks to me and others I have been close to, including my family.
- Answer all my questions about my TB care and medicines.
- Provide all medical care related to my TB. and share this information with my other doctors if appropriate.
- Tell me about any changes in my health (laboratory tests, x-rays, etc.).
- Make sure that I get my TB medicines at a time we agree to, including DOT appointments.
- Keep my health information confidential in accordance with Federal and state (HIPPA) regulations.

Treatment Agreement:

- I agree to keep all scheduled appointments for receiving TBs medication, to take all TB medication as prescribed, to comply with all diagnostic tests ordered by my doctor and to follow all other directions given to me by the _____ County TB staff.
- If I fail to comply, I understand I may be quarantined in a state hospital with facilities for tuberculosis treatment or other appropriate facility as determined by the state and local health department by authority granted to the Health Officer by *Annotated Code of Maryland, Health-General §§ 18-324,325* and the *Code of Maryland Regulations 10.06.01.06, General Control Measures for Communicable Diseases.*
- I have read or had this agreement read to me, have had my questions answered, understand the significance of my treatment for myself and others. I have been given a copy of this form to keep with my own records.

_____ (print) _____ (print)

_____ (signature) _____ _____ (signature) _____

Patient or Parent/Guardian **Date** **TB Staff/Provider** **Date**

MDH 4511 (revised 2018)