Adolescent Behavioral Health Informed Consent for Treatment

Welcome to Fredericksburg Christian Health Center (FCHC) Behavioral Health Counseling! This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

Behavioral Health Services

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. I, as your therapist, have corresponding responsibilities to you. These rights and responsibilities are described in the following sections. Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing the unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen.

Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions. The first session will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with me. If you have questions about my procedures, we should discuss them whenever they arise. If your doubts persist, I will be happy to help you set up a meeting with another mental health professional for a second opinion.

Our Financial Policy

TO ALL PATIENTS:

We ask that all patients pay for their office visit at the time of service, unless you have prior arrangements made with our billing department or payment plan agreement.

*Fee service schedule will be determined at the time of registration.

TO OUR PATIENT'S WITH INSURANCE COVERAGE:

If you have a co-pay with your insurance, you must pay it at each office visit. We will be happy to file all charges with your insurance once you have given us your complete insurance information. We will ask to run a copy of your insurance card. Insurance information must be provided within 30 days of the appointment, or the patient will be made a self-pay. **However, if your insurance does not pay within 90 days, it is your responsibility to contact them in reference to payment.** If you do not want us to file with your insurance, please let us know. Please contact our billing department for any assistance you may need. You will be reimbursed for any overpayment made to us or your insurance will be reimbursed for overpayments made by your insurance company.

MEDICARE PATIENTS:

Medicare requires all Medicare patients to sign the following before we can file your claim. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Powell for any services furnished by that physician. I authorized any holder of medical information about me to release the Health Care Financing Administration and it's agents, and to my insurance company, any information needed to determine these benefits or the benefits payable to related services.

_____	_____	_____
Medicare ID #	Signature of Medicare Patient	Date

ALL PATIENTS OR GARANTOR PLEASE REED AND SIGN THE FOLLOWING:

I have read and understand all of the above. The information listed by me on the front is correct to the best of my knowledge. I am responsible for bills not paid by insurance. I further agree in the event of nonpayment, to bear the cost of collection, and/or Court costs and reasonable legal fees should this be required. It is agreed that a photocopy serves at the original of this document. I have also read and understand all HIPAA rules designated on the Notice of Privacy Practices. If I do not want any of my PHI disclosed I agree to sign another form for that authorization.

_____	_____
Signature of Patient	Date

INSURANCE AND COMPENSATION PATIENTS PLEASE READ AND SIGN THE FOLLOWING:

I authorize the release of medical information to my insurance carrier(s) and authorized insurance payment directly to Fredericksburg Christian Health Center.

_____ _____

Signature of Patient Date

GUARANTOR FOR THIS PATIENT/ACCOUNT

_____ _____ _____

Print Name Signature Date

Professional Records

I am required to keep appropriate records of the psychological services that I provide. Your records are maintained in a secure location in our electronic record system. I keep brief records noting that you were here, your reasons for seeking therapy, the goals and progress we set for treatment, your diagnosis, topics we discussed, your medical, social, and treatment history, records I receive from other providers, copies of records I send to others, and your billing records. Except in unusual circumstances that involve danger to yourself, you have the right to a copy of
your file.

Because these are professional records, they may be misinterpreted and / or upsetting to untrained readers. For this reason, I recommend that you initially review them with me, or have them forwarded to another mental health professional to discuss the contents. If I refuse your request for access to your records, you have a right to have my decision reviewed by another mental health professional , which I will discuss with you upon your request. You also have the right to request that a copy of your file be made available to any other health care provider at your written request.

Confidentiality

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Behavioral Health Notice of Privacy Practices and . You have been provided with a copy of that document and we have discussed those issues. Please remember that you may reopen the conversation at any time during our work together.

Contacting Us

I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a brief voicemail and your call will be returned within 2 business days if it a non-urgent matter. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe,

1) contact your local Community Service Board Emergency Services Line:
   Rappahannock Area Community Service Board Emergency Services Numbers
   - Fredericksburg, Spotsylvania & Stafford: **(540) 373-6876**
   - King George: **(540) 775-5064**
   - Caroline County: **(540) 633-4148**

2) If safely able to do so, go or get someone you trust to take you to your Local Hospital Emergency Room, **or**

3) **Call 9-1-1**. I will make every attempt to inform you in advance of planned absences.

Other Rights

If you are unhappy with what is happening in therapy, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and

respect. You may also request that I refer you to another therapist and are free to end therapy at any time. You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender identity, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

Termination of Services

If the clinician and/or clinical supervisor/owner determine appropriate services can no longer be provided to you or your child, for any reason treatment will be terminated and referrals to other services will be provided.

If you do not attend two appointments consecutively, and do not call the office the same day, a phone call will be placed for you to call back and check-in with your counselor and/or reschedule and the **Behavioral Health Emergency Contact Release Form** procedure will be utilized.

If you are a no show, no call for your third consecutive appointment, then a _ letter requesting you to contact our office, will be mailed to your permanent address on file, and uploaded into MyChart. This letter will outline a deadline date for you to contact the office. If you do not contact and/or reschedule your appointment, behavioral health services will be terminated.

Adolescent Behavioral Health Telehealth Informed Consent

I, _____ hereby consent to engage in Telehealth with Fredericksburg Christian Health Center (FCHC)'s Behavioral Health Department.

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g. Internet or phone) to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

3. I understand that miscommunication between myself and my therapist may occur via Telehealth.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

9. I have discussed the fees charged for Telehealth with my therapist and agree to them [or for insurance patients: I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the patient's responsibility (e.g. co-payments)], and I have been provided with this information in the Informed Consent Form.

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

_____

Patient's Signature

_____

Patient's Printed Name

_____

Date

_____

Parent/Guardian Signature

_____

Parent/Guardian Printed Name

_____

Date

Adolescent Behavioral Health Notice of Privacy Practices
THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

As a rule, I will disclose no information about you, or the fact that you are my patient, without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. Health care providers are legally allowed to use or disclose records or information for treatment, payment, and health care operations purposes. However, I do not routinely disclose information in such circumstances, so I will require your permission in advance, either through your consent at the onset of our relationship (by signing the attached general consent form), or through your written authorization at the time the need for disclosure arises. You may revoke your permission, in writing, at any time, by contacting me. Fredericksburg Christian Health Center (FCHC) adheres to the federal and state laws addressing Privacy & Confidentiality such as the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191 The Privacy Rule is located at CFR 45 Parts 160 and Subparts A and E of 164; and Title 42 CFR Confidentiality of Substance Use Disorder Patient Records Chapter 1, Part 2, plus applicable state laws

II. Limits of Confidentiality

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization
There are some important exceptions to this rule of confidentiality – some exceptions created voluntarily by my own choice, [some because of policies in this office/agency], and some required by law. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits. We will discuss these issues now, but you may reopen the conversation at any time during our work together. I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· **Emergency:** If you are involved in a life-threatening emergency and I cannot ask your permission, I will share information if I believe you would have wanted me to do so, or if I believe it will be helpful to you.

· **Health Oversight:** Virginia law requires that licensed psychologists [social workers; counselors] report misconduct by a health care provider of their own profession. By policy, I also reserve the right to report misconduct by health care providers of other professions. By law, if you describe unprofessional conduct by another mental health provider of any profession, I am required to explain to you how to make such a report. If you are yourself a health care provider, I am required by law to report to your licensing board that you are in treatment with me if I believe your condition places the public at risk. Virginia Licensing Boards have the power, when

necessary, to subpoena relevant records in investigating a complaint of provider incompetence or misconduct.

· **Workers Compensation:** If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

· What to Expect as an Adolescent (Additional Limits to Confidentiality)
The purpose of meeting with a counselor or therapist is to get help with problems in your life that are bothering you or that are keeping you from being successful in important areas of your life. You may be here because you wanted to talk to a counselor or therapist about these problems. Or, you may be here because your parent, guardian, doctor or teacher had concerns about you. When we meet, we will discuss these problems. I will ask questions, listen to you and suggest a plan for improving these problems. It is important that you feel comfortable talking to me about the issues that are bothering you. Sometimes these issues will include things you don't want your parents or guardians to know about. For most people, knowing that what they say will be kept private helps them feel more comfortable and have more trust in their counselor or therapist. Privacy, also called confidentiality, is an important and necessary part of good counseling.

As a general rule, I will keep the information you share with me in our sessions confidential, unless I have your written consent to disclose certain information. There are, however, important exceptions to this rule that are important for you to understand before you share personal information with me in a therapy session. In some situations, I am required by law or by the guidelines of my profession to disclose information whether or not I have your permission. I have listed some of these situations below.

Confidentiality <u>CANNOT</u> be maintained when:

- You tell me you plan to cause serious harm or death to yourself, and I believe you have the intent and ability to carry out this threat in the very near future. I must take steps to inform your parent or guardian, and I must inform the person and/or the potential victims if under 18 years old; of what you have told me and how serious I believe this threat to be. I must make sure that you are protected from harming yourself. These precautions may also include:
    1. warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18,
    2. 2) notifying a law enforcement officer, or
    3. 3) seeking your hospitalization.
        a. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.
        b. If you become a party in a civil commitment hearing, I can be required to provide your records to the magistrate, your attorney or guardian ad litem, a CSB evaluator, or a law enforcement officer.

- You are doing things that could cause serious harm to you or someone else, even if you do not intend to harm yourself or another person. In these situations, I will need to use my professional judgment to decide whether a parent or guardian should be informed.

- You tell me you, another minor, elderly and or a disabled adult are being abused-physically, sexually or emotionally-or that you have been abused in the past. In this situation, I am required by law to report the abuse to the Virginia Department of Social Services.

- You are involved in a court case and a request is made for information about your counseling or therapy. If this happens, I will not disclose information without your written agreement unless the court requires me to. I will do all I can within the law to protect your confidentiality, and if I am required to disclose information to the court, I will inform you that this is happening.

- Your Records (Due to Being a Minor): Virginia has a number of laws that limit the confidentiality of the records of minors. For example, parents, regardless of custody, may not be denied access to their child's records; and CSB evaluators in civil commitment cases have legal access to therapy records without notification or consent of parents or child.

- <u>Communicating with your parent(s) or guardian(s):</u>
  Except for situations such as those mentioned above, I will not tell your parent or guardian specific things you share with me in our private therapy sessions. This includes activities and behavior that your parent/guardian would not approve of — or would be upset by — but that do not put you at risk of serious and immediate harm. However, if your risk-taking behavior becomes more serious, then I will need to use my professional judgment to decide whether you are in serious and immediate danger of being harmed. If I feel that you are in such danger, I will communicate this information to your parent or guardian.

Example: If you tell me that you have tried alcohol at a few parties, I would keep this information confidential. If you tell me that you are drinking and driving or that you are a passenger in a car with a driver who is drunk, I would not keep this information confidential from your parent/guardian. If you tell me, or if I believe based on things you've told me, that you are addicted to alcohol, I would not keep this information confidential.

Example: If you tell me that you are having protected sex with a boyfriend or girlfriend, I would keep this information confidential. If you tell me that, on several occasions, you have engaged in unprotected sex with people you do not know or in unsafe situations, I will not keep this information confidential. You can always ask me questions about the types of information I

would disclose. You can ask in the form of "hypothetical situations," in other words: "If someone told you that they were doing _____, would you tell their parents?"

Even if I have agreed to keep information confidential – to not tell your parent or guardian – I may believe that it is important for them to know what is going on in your life. In these situations, I will encourage you to tell your parent/guardian and will help you find the best way to tell them. Also, when meeting with your parents, I may sometimes describe problems in general terms, without using specifics, in order to help them know how to be more helpful to you.

You should also know that, by law in Virginia, your parent/guardian has the right to see any written records I keep about our sessions. It is extremely rare that a parent/guardian would ever request to look at these records.

Communicating with other adults:

School: I will not share any information with your school unless I have your permission and permission from your parent or guardian. Sometimes I may request to speak to someone at your school to find out how things are going for you. Also, it may be helpful in some situations for me to give suggestions to your teacher or counselor at school. If I want to contact your school, or if someone at your school wants to contact me, I will discuss it with you and ask for your written permission. A very unlikely situation might come up in which I do not have your permission but both I and your parent or guardian believe that it is very important for me to be able to share certain information with someone at your school. In this situation, I will use my professional judgment to decide whether to share any information.

Doctors: Sometimes your doctor and I may need to work together; for example, if you need to take medication in addition to seeing a counselor or therapist. I will get your written permission and permission from your parent/guardian in advance to share information with your doctor. The only time I will share information with your doctor even if I don't have your permission is if you are doing something that puts you at risk for serious and immediate physical/medical harm.

III. Patient's Rights and Provider's Duties:

· **Right to Request Restrictions**-You have the right to request restrictions on certain uses and disclosures of protected health information about you. You also have the right to request a limit on the medical information I disclose about you to someone who is involved in your care or the payment for your care. If you ask me to disclose information to another party, you may request that I limit the information I disclose. However, I am not required to agree to a restriction you request. To request restrictions, you must make your request in writing, and tell me:

1) what information you want to limit;
2) whether you want to limit my use, disclosure or both; and
3) to whom you want the limits to apply.

· **Right to Receive Confidential Communications by Alternative Means and at Alternative Locations**
— You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address. You may also request that I contact you only at work, or that I do not leave voice mail messages.) To request alternative communication, you must make your request in writing, specifying how or where you wish to be contacted.

· **Right to an Accounting of Disclosures** – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in section III of this Notice). On your written request, I will discuss with you the details of the accounting process.

· **Right to Inspect and Copy** – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing. If you request a copy of the information, I may charge a fee for costs of copying and mailing. I may deny your request to inspect and copy in some circumstances. I may refuse to provide you access to certain psychotherapy notes or to information compiled in reasonable anticipation of, or use in, a civil criminal, or administrative proceeding.

· **Right to Amend** – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and submitted dot me. In addition, you must provide a reason that supports s your request. I may deny your
request if you ask me to amend information that:
1) was not created by me; I will add your request to the information record;
2) is not part of the medical information kept by me;
3) is not part of the information which you would be permitted to inspect and copy;
4) is accurate and complete.

· **Right to a copy of this notice** – You have the right to a paper copy of this notice. You may ask me to give you a copy of this notice at any time. Changes to this notice: I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future. The notice will contain the effective date. A new copy will be given to you or posted in the waiting room. I will have copies of the current notice available on request.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you must submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.

EFFECTIVE DATE: ____/____/2023__

Acknowledgement of Behavioral Health Notice of Privacy Practices

I acknowledge that I may review the Privacy Policy found on the EPIC and the practice website's services page for Fredericksburg Christian Health Center (FCHC) The Notice of Privacy Policy provides detailed information about how the practice may use and disclose my confidential information.

I understand that my therapist has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be available to me upon a written request to the Privacy Officer.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to my therapist. I also understand that I will not be able to revoke this consent in cases where the therapist has already relied on it to use or disclose my mental health information. Written revocation of consent must be sent to our office.

I understand that I have the right to request that the practice restricts how my individually identifiable mental health information is used and/or disclosed to carry out treatment, payment or health operations. I understand that the practice does not have to agree to such restrictions, but that once such restrictions are agreed to, the practice and their agents must adhere to such restrictions.

Signed:_____ Date:_____

If you are not the patient, please specify your relationship to the patient_____.

Adolescent Consent Form
&
Parent Agreement to Respect Privacy

Adolescent Client:

Signing below indicates that you have reviewed the policies described above and understand the limits to confidentiality. If you have any questions as we progress with mental health counseling, you can ask your counselor at any time.

Minor's Signature _____ Date_____

* * *

Parent/Guardian:

Check boxes and sign below indicating your agreement to respect your child's privacy:

☐I will refrain from requesting detailed information about individual sessions with my child. I understand that I will be provided with periodic updates about general progress, and/or may be asked to participate in therapy sessions as needed.

☐Although I know that in this state, I have the legal right to request written records/session notes since my child is a minor. However, I am aware that requesting records could inhibit the therapeutic relationship with the counselor and could result in the discontinuation of services.

☐I understand that I will be informed immediately about situations that could endanger my child. I know this decision to breach confidentiality in these circumstances is up to the counselor's professional judgment and may sometimes be made in confidential consultation with her consultant/supervisor.

Parent/Legal Guardian Signature _____ Date_____

Parent/Legal Guardian Signature _____ Date_____

Counselor Signature _____ Date_____

Adolescent Consent for Behavioral Health Services

Your signature below indicates that you have read this Agreement and the Behavioral Health Notice of Privacy Practices and informed consent, and agree to their terms

_____

Signature of Patient and or Parent/Legal Guardian

_____

Printed Name of Patient and or Parent/Legal Guardian

_____

Date

Description of Personal Representative's Authority:_____

_____

Signature of Counselor/Clinician

_____

Printed Name of Counselor/Clinician

Date _____

Behavioral Health Emergency Contact Release Form

_____ _____ _____

Name MRN#: Date of Birth

Provider/Requester: I _____hereby authorize Fredericksburg Christian Health Center (FCHC) to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name: _____

_____

Address:

_____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

For the purpose of: **CARE DURING A MEDICAL OR MENTAL HEALTH (SUICIDAL/HOMICIDAL EMERGENCY) AND/OR WELLNESS CHECK**

The information authorized to be released (please initial below):

_____ Any information related to a medical or mental health concern or emergency

_____ Any information needed to verify and/or secure safety when suicidal or homicidal

_____ Any information (minimum necessary) to provide wellness check in the event that patient is a "No-show" for any scheduled appointments after 15 minute grace period - no phone call was made to counselor/clinician from the Patient to cancel or reschedule appointment; and, counselor/clinician has made 3 attempts to contact patient without a returned call from the patient. A phone call to the emergency contact on file will be made. In the event that emergency contact is unable to be reached after 3 calls with no returned phone call from emergency contact; and/or there is a 1) clinical concern/reason to do so, a counselor/clinician will contact law-enforcement to complete a wellness/safety check on the patient.

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent that action has been taken on it already; and that is required as outlined in the Notice of Privacy Practices form signed by me during intake: "**Confidentiality <u>CANNOT</u> be maintained when:**".

I further understand that Fredericksburg Christian Health Center (FCHC) will not condition my treatment on whether I give authorization for the requested disclosure.

_____ _____

Client Signature Date

_____ _____

Parent/ Legal Guardian Signature Date

_____ _____

Witness (Counselor/Clinician) Signature Date

Release valid from _____ to _____

BEHAVIORAL HEALTH AUTHORIZATION TO RELEASE/
EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize Fredericksburg Christian Health Center (FCHC) to:

□ release to: □ obtain from: □ exchange with:

_____

_____

The following information pertaining to myself:
□ Treatment Summary
□ Assessment and Progress (Counseling/Therapy) Notes
□ Discharge Summary
□ History/Intake
□ Diagnosis
□ Psychological Test Results
□ Psychiatric Evaluation/Medication History
□ Dates of Treatment Attendance
□ Other (specify) _____
For the purpose of:
□ Evaluation/Assessment
□ Continuity of Care/ Coordinating Treatment Efforts
□ Other (specify) _____

MRN#:_____
Date of Birth:_____

Phone Number: _____

I understand that this Release of Information expires one year from today's date: _____ to _____. I also understand that if I have any questions about my clinical records, or the content within, I can contact authorize Fredericksburg Christian Health Center (FCHC) and someone will meet with me to discuss my records.

I understand that this information are protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Title 45 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically

expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Signature of Staff Date