Behavioral Health HIPAA Authorization

Name: (Last)_____ (First)_____ (MI) ____ Date of Birth:_____

Printed Name of Parent or Legal Guardian (If applicable): _____

Health Insurance Portability and Accountability Act (HIPAA) Authorization

I authorize **Center Street Community Health Center and Morrow Family Health Center** to use and disclose my following **Protected Health Information (PHI)** listed below for the purposes listed elsewhere on the page.

List individuals you would allow us to share medical information with if necessary.

Name of entity or person(s) to receive information:

Upon supplying proof of identity by showing acceptable form of photo identification, the above listed person(s) may have access to my: medications, prescriptions, documentation in sealed envelope, appointment time, and any life-threatening, emergency information.

This Protected Health Information (PHI) is being given or disclosed for the following purpose(s): Continuity of Care

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Center Street Community Health Center Corporate office. I understand that revocation is not effective to the extent that my provider has relied on the use or disclosure of the PHI or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. The use or disclosure requested under this authorization may result in direct or indirect remuneration to the provider from a third party.

If the disclosure concerns a patient in an alcohol or drug abuse program, the following notice shall accompany the disclosure: This information has been disclosed to you from our records protected by federal confidentiality rules (442CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly 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.

I SPECIFICALLY AUTHORIZE THE DISCLOSURE TO & RELEASE FROM ABOVE NOTED AGENCIES REGARDING THE INFORMATION:

___ Mental Health Information- current diagnosis & medication list ___ Substance abuse (including alcohol/drug abuse)

___ STD related information (STD testing) ___ HIV related information (AIDS related testing)

Professional Records

I understand that the laws and standards of the Behavioral and Mental Health Services profession require that Center Street Community Health Center and Morrow Family Health Center keep Protected Health Information (PHI) about me or my child in a clinical record. A clinical record includes information about reasons for seeking treatment, a description about the ways in which the problems affect me or my child's life, diagnosis, treatment goals, progress towards goals, medical and social history, treatment history, results of clinical tests (including raw test data), past treatment records received from other providers, reports of professional consultations, and payment records. If requested in writing, I may examine or receive a copy of the clinical record, except in unusual circumstances where to do so would be to put myself, my child, or another person at risk of substantial harm. I understand that because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. Information received from other entities will not be re-disclosed to patients.

For patients under 18 years of age I am aware that the law may provide my parents the right to examine my treatment records. Before giving parents any information, my provider will discuss the matter with me, if possible, and do their best to handle my concerns or objections.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.

Behavioral Health Consent to Treat

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Consent for Treatment

I understand that treatment provided to me by any medical, dental, nursing students, LISW, or PsyD staff will be properly supervised by a licensed practitioner. I am giving permission for any exams, tests, or other services that the provider believes are needed. Center Street Community Health Center and Morrow Family Health Center makes sure that all staff who need licensed by the State of Ohio have the proper credentials.
I understand and agree that I will participate in the planning of my care, treatment, and/or services. I understand that I may stop care, treatment, and/or services at any time. I also understand that there are no guarantees that treatment will be successful.

CSCHC and MFHC have right to treat me without consent only in three situation:

1) Emergencies 2) When non-verbal communications show implied consent 3) When legally bound to treat.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.

Behavioral Health Warn and Inform Acknowledgement

Name: (Last)_____ (First)_____ (MI) _____ Date of Birth: _____

Printed Name of Parent or Legal Guardian (If applicable): _____

Warn or Inform Third Parties Acknowledgement

I understand that the law protects the privacy of all communication between myself or my child and a provider. In most situations, Center Street Community Health Center and Morrow Family Health Center can only release information about my or my child's treatment to others if a written authorization form is signed. I understand that there are some situations where Center Street Community Health Center and Morrow Family Health Center are permitted or required to disclose information either with or without consent or authorization. For example: if I or my child report that any adult has been physically abusive, sexually abusive, emotionally abusive, or neglectful towards a minor, an elderly, or a developmentally disabled person, Center Street Community Health Center and Morrow Family Health Center must report this to Children's Services or the appropriate authorities. If Center Street Community Health Center and Morrow Family Health Center believes I or my child present a clear and substantial danger to harm myself, themselves or someone else, protective actions will be taken. This may include contacting family members, seeking hospitalizations, notifying any potential victims, and notifying the police. If I or my child are involved in a court proceeding and a request, also known as a court order, is made by the judge for information concerning my or my child's treatment, then authorization for release of information is not required. If I or my family are involved in litigation, I should consult with my attorney to determine whether a court would likely require Center Street Community Health Center and Morrow Family Health Center to disclose information.

Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If you do not agree with these terms, we will be unable to serve as your provider.