



## **Informed Consent for Counseling and Psychotherapy for Minors**

### **Mental Health Services**

Ethos Clinics recognizes that it may not be easy to seek help from a mental health professional; we hope that with our help you will be better able to understand your situation and feelings and will be able to move towards resolving your difficulties. The therapist will strive to *assist* you grow towards greater health and wholeness by providing counseling services within a biopsychosocial, cognitive-behavioral perspective. Our therapist works within the context of each individual's beliefs, and no attempt is made to impose personal theology.

### **Therapist**

The therapist is a trained professional engaged in providing mental health care services to clients directly as an employee of Ethos Clinics. The therapist has discussed with me the various aspects of psychotherapy. This includes a discussion of the evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment has been described, including the extent, its possible side effects, and possible alternative forms of treatment. You may withdraw from treatment at any time, but please discuss this with your therapist.

### **Appointments and Cancellations**

Appointments are made by calling the office location most convenient for you (Lehigh: 610-900-4234, Bethlehem: 610-625-1486, Emmaus: 484-232-5288), Monday through Friday, between the hours of 9:00am and 5:00pm. If you are unable to get through when you call please leave a message with your name, purpose of your call, and a call back number and a staff member will get back to you within 72 hours. Please call to cancel or reschedule at least 24 hours in advance, or you will be charged for the missed appointment and the absence will be marked on your record. Third-party payments will not usually cover reimburse for missed appointments. Medicaid clients are not charged a fee per the law, but will be held accountable to the office No Show and Cancellation Policy (See the No Show and Cancellation Policy form). Your therapist reserves the right to cancel your appointment if you show up sick, late, or with minor children that might interfere with the counseling session.

### **Number and Length of Sessions**

The number of sessions needed depends on many factors and will be discussed by the therapist. The length of therapy sessions range depending on several factors and the therapist will discuss this with you as well.

### **Relationship**

Your relationship with the therapist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the therapist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. The therapist cares about helping you but is not in a position to be your friend or to have a social and personal relationship with you. Gifts, bartering and trading services are not appropriate and should not be shared between you and the therapist.

### **Goals, Purposes, and Techniques of Therapy**

There may be multiple interventions to effectively treat the problems that you are experiencing. It is important for you to discuss any questions you may have regarding the treatment recommended by the



therapist and to have input in setting goals of your therapy. As therapy progresses, these goals may change.

### **Confidentiality**

Discussions between a therapist and a client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; AIDS/HIV infection and possible transmission; criminal prosecutions; child custody cases, suits in which the mental health of a party is in issue; situations where the therapist has a duty to disclose, or where, in the therapist's judgment, it is necessary to warn, notify, or disclose; fee disputes between the therapist and the client; a negligence suit brought by the client against the therapist; or the filing of a complaint with a licensing board or other state or federal regulatory authority.

If you have any questions regarding confidentiality, you should bring them to the attention of the therapist when you and the therapist discuss this matter further. By signing the Receipt form for the Informed Consent and Privacy Practices, you are giving consent to the therapist to share confidential information with all persons mandated by law, with the agency that referred you, and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services. You are also releasing and holding harmless the therapist from any departure from your right to confidentiality that may result.

### **Duty to Warn**

In the event that the therapist reasonably believes that the client is in danger, physically or emotionally, to themselves or another person, consent is given for the therapist to warn the person in danger and to contact any person in a position to prevent harm to themselves or another person, including law enforcement and medical personnel. This authorization shall expire upon the termination of therapy.

By signing Informed Consent and Privacy Practices form, you acknowledged that you have the right to revoke this authorization in writing at any time to the extent the therapist has not taken action in reliance on this observation. You further acknowledge that even if you revoke this authorization, the use and disclosure of your protected health information could possibly still be permitted by law as indicated in the Notice of Privacy Practices section of this form. You acknowledge that you have been advised by the therapist of the potential of the re-disclosure of your protected health information by authorizing recipients, and that it will no longer be protected by the federal Privacy Rule. You further acknowledge that the treatment provided to you by the therapist was conditioned on you providing this authorization.

### **Risks of Therapy**

Therapy is the Greek word for *change*. Clients often learn things about themselves that they don't like. Often growth cannot occur until past issues are experienced and confronted, often causing distressing feelings such as sadness and anxiety. The success of therapy depends upon the quality of the efforts of both the therapist and client, along with the reality that clients are responsible for the lifestyle choices/changes that may result from therapy. Specifically, one risk of marital therapy is the possibility of exercising the divorce option.

### **Payment for Services**



If you have insurance, different copayments are required by various group coverage plans. Your copayment is based on Mental Health Policy selected by your employer or purchased by you. You are responsible for and shall pay your copay portion of therapist's charges for services at the time services are provided. You are responsible for notifying Ethos Clinic immediately of any changes to your insurance. If you fail to notify Ethos Clinic of any changes to insurance, you may be billed for services that are not covered. **Ethos will look to you for full payment of your account, and you will be responsible for payment of all charges.**

### **Court**

Although it is the goal of the therapist to protect the confidentiality of your records, there may be times when disclosure of your records or testimony will be compelled by the law. In the event disclosure of your records or therapist's testimony are requested by you or required by law, you will be responsible for and shall pay the costs involved in producing the records and the therapist's normal hourly rate for giving that testimony. Such payments are to be made prior to the time the services are rendered by the therapist. The therapist may require deposit for anticipated court appearances and preparation.

### **After-Hour Emergencies**

Emergencies are defined as urgent issues requiring immediate action. **If you are experiencing a psychiatric or medical emergency and reach the business after hours, call or report to your local emergency room immediately.** Other national resources include, but are not limited to: Suicide Prevention Hotline, 1-800-273-8255 ;MH Warm Line, (866) 854-8114 ;Suicide Prevention Text Services: text 741741; <https://suicidepreventionlifeline.org/> ; <http://www.yourlifeyourvoice.org>

### **Therapist's Incapacity or Death**

In the event the therapist becomes incapacitated or dies, it will become necessary for another therapist to take possession of client records. By signing Informed Consent and Privacy Practices Receipt, you give consent to another licensed mental health professional at Ethos Clinic to take possession of your files and records and provide you with copies upon request, or to deliver them to a therapist of your choice.

### **Consent to Treatment**

By signing Informed Consent and Privacy Practices Receipt, you voluntarily agree to receive mental health assessment, care, treatment or services and authorize the therapist to provide such care, treatment, or services as are considered necessary and advisable. Signing indicates that you understand and agree that you will participate in the planning of your care, treatment, or services, and that you may stop such care, treatment or services at any time. By signing the informed Consent and Privacy Practices Receipt, you acknowledge that you have both read and understood all the terms and information contained herein. Ample opportunity has been offered for you to ask questions and seek clarification of anything that remains unclear.

### **Contact Information**

By signing the Informed Consent and Privacy Practices Receipt, You are consenting for Ethos Clinic to communicate with you by mail, e-mail, and phone at the address and numbers provided at the initial appointment, and you will immediately advise Ethos Clinic in the event of any change. You agree to notify the Center if you need to opt out of any form of communication.



**General Consent for Care and Medical Treatment**

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 this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. 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.

Client Name Print \_\_\_\_\_ DOB: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name Print: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name Print: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Intent Of Treatment Waiver

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By signing this Document I acknowledge that any evaluation, assessment, therapy or medication management is for the treatment of the client as an individual, and *is not* to be used for the purpose of determining parental competency or custody. Such an evaluation should be conducted by an independent evaluator designed for that specific purpose.

Client Printed Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Printed Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HIPAA Patient Consent Form**

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The practice may utilize Surescripts to assist in the continue of care for medication management.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

This consent was signed by: \_\_\_\_\_  
(PRINT NAME PLEASE)

Signature: \_\_\_\_\_



428 S 7<sup>th</sup> st  
Lehighton PA 18235  
P: 610-900-4234

3835 chestnut street  
Emmaus PA 18049  
P: 484-232-5288

FAX: 570-392-6143

## **Paperwork/Forms Policy:**

Please be advised that no Time Off, FMLA, or Disability paperwork/forms will be filled out for patients who are not established with the practice. To be established with the practice the patient must have been seen by one Ethos Clinic physician for a minimum of 2 consecutive visits. From the 3rd visit on, it is at the provider's discretion, to assist with the above-mentioned paperwork based on medical necessity. Providers require 10-14 business days to complete any documents.

Additionally, a completion fee of \$25 for short documents and \$75 for long documents will be charged to account for the time required for providers to complete the paperwork.

Kindest Regards,

Ethos Clinic

My signature indicates that I have read and understand the policy above.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



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## Medication Policy:

Please call with medication refill concerns at least 1 week prior to completion of current prescription, to prevent gaps in medication. Refill requests will be processed within 2 business days (48-hour period), of when request is received (i.e., if request is given after business hours, on a weekend, or a holiday the office will address this concern when it is received on the next scheduled business day).

Kindest Regards,

Ethos Clinic

My signature indicates that I have read and understand the policy above.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_





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## Missed Appointment Policy

In order to provide the best service to our patients, we have established the following policy.

### Definitions:

- **No-Show:** not showing for a scheduled appointment without prior notice.
- **Late Cancel:** canceling an appointment with less than 24 hour notice (this is also considered a No-Show for attendance purposes).
- **Cancel:** cancelling an appointment with more than 24 hours notice.

### Initial Appointments:

- If you **No-Show** your intake appointment, you will not be eligible for rescheduling.
- If you **No-Show** your initial therapy/provider appointments, you will not be eligible for reschedule for 3 months.
- If you **Late-Cancel** your initial appointments, your ability to reschedule will be at the discretion of the practice manager.
- If you **Cancel** your initial appointment you will be eligible for rescheduling based on provider/clinician schedule availability.

### Ongoing Appointments:

- Two **No-Shows** and/or **Late Cancellations** with less than 24 hours notice for therapy, within a calendar year, will result in a 6 month therapeutic break.
  - If terms are met for a 2nd therapeutic break this would result in discharge from therapy.
- Two **No-Shows** and/or **Late Cancellations** with less than 24 hours notice, within a calendar year, for the medication management provider will be grounds for case review and potential discharge from Ethos Clinic.

Very often there are understandable and unavoidable reasons for missing appointments, however, a missed appointment prevents another patient from receiving services. This has a significant impact on our practice and the care we provide. If you **No-Show** or **Late Cancel** an appointment, there will be a **\$30.00 no-show fee**. This fee is to be paid at your next scheduled visit. Our policy is to best service you.

My signature indicates that I have read and understand the policy above.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



## **Patient Medication Agreement**

I, \_\_\_\_\_, have reviewed, understand and voluntarily agree with the following statements:

- I will keep (and be on time for) all of my scheduled appointments with the doctor and other members of the treatment team.
- I will participate in all other types of treatment that I am asked to participate in.
- I will keep medication safe, secure, and out of the reach of children. If my medication is lost or stolen, I understand that it will not be replaced until my next appointment or may not be replaced at all.
- I will take medication as instructed and not change the way that I take it without first talking to the doctor or other member of the treatment team.
- I understand that prescriptions will be filled during scheduled office visits with the treatment team and have reviewed the refill policy.
- I will make sure that I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the treatment team immediately.
- I will treat the staff respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment may be stopped.
- I will not sell my medications or share them with others. I understand that if I do, my treatment will be stopped.
- I will sign a release form to let my doctor speak to all other doctors or providers that I see.
- I will tell the doctor all other medicines that I take, and let him/her know right away if I have a prescription for a new medication.
- I will tell the doctor or a treatment team member immediately if I am pregnant or planning to become pregnant.
- I will not get any opioid pain medications or other controlled medicines that can be addictive such as benzodiazepines (xanax, klonopin, valium) or stimulants (ritalin, amphetamine) without telling a member of the treatment team BEFORE I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.
- I will use only one pharmacy to get all of my prescriptions: \_\_\_\_\_  
Pharmacy Name/ Phone #
- I will not use illegal drugs such as heroin, cocaine, marijuana (illicit not MMJ if prescribed to me) or amphetamines. I understand that if I do, my treatment may be stopped.
- If necessary for my individual treatment I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will be considered positive for drugs.
- I will keep up to date with any bills from the office and tell the doctor or member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.
- I understand that I may lose my right to treatment in this office if I break any part of this agreement.

PRINTED NAME \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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## Ethos Clinic ADHD Policy

Please be advised that Ethos Clinic will not be accepting new adult ADHD patients unless the patient is able to provide a recent neuropsychological evaluation that demonstrates this diagnosis. In order to obtain a neuropsychological evaluation, you can call the member services number on the back of your insurance card and ask what providers may be in network. If your insurance requires a referral for this type of evaluation, we urge the patient to reach out to their PCP, in order to complete appropriate neuropsychological testing prior to starting treatment at Ethos Clinic.

PRINTED NAME \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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## Duty Of Payment

I \_\_\_\_\_, have requested Ethos Clinic to bill my insurance on my insurance on my behalf for payment of services. I clearly understand that it is my responsibility to be financially responsible for services rendered.

This is including but not limited to : insurance adjustment, denied claims or services not covered by my plan. If there is a balance owed on my account, I agree to make arrangements for prompt payment.

I understand if my benefits or coverage should change while I am receiving treatment, I must notify Ethos Clinic immediately in order for proper insurance claims information to be submitted on my behalf.

Furthermore, if my insurance company doesn't pay the provider directly, I agree to relinquish payment to Ethos Clinic upon receipt of the check.

My signature indicate that I have read and understand the policy above.

PRINTED NAME \_\_\_\_\_ PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Signature of policy holder if different from patient:

PRINTED NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_



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## Patient Consent for Electronic Prescribing

Ethos Clinic has implemented e-prescribing as part of an on-going effort to improve your health care. It is a system used to submit prescriptions electronically to the pharmacy of your choice. E-prescribing creates a more efficient and safe process for patients to access their medications. It helps to prevent, and in some case eliminate, the top reasons for prescription errors- including illegible handwriting, incorrect dosing and missed drug/allergy interactions. This improves patient care and safety and decreases medication errors.

E-prescribing also systems also store and transmit your prescription information with medication history to your health care providers and insurers. This allows for information to be obtained quickly about the drugs covered under your benefit plan, as well as the drugs you may already be taking to minimize adverse drug events.

By signing below, you provide your consent to Ethos Clinic and its providers to electronically submit your prescription through the e-prescribing system described above. You are also consenting for your provider to request and use your prescription medication history, from other healthcare providers and or third-party pharmacy benefit payors, for treatment purposes.

This consent will remain in effect until you withdraw it. You may withdraw at any time except to the extent it has already been relied upon. Your decision not to sign this form will not affect your ability to receive medical care, or your ability to receive your prescription through alternative means.

PRINTED NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Suicide/Crisis Management Plan**  
(required for **ALL** patients)

**Patient Name:** \_\_\_\_\_

**3 Warning signs:** (ways to recognize that your mental health symptoms are worsening)

- 1.
- 2.
- 3.

**3 Internal Coping Strategies:** (3 things to distract without contacting another person: i.e. relaxation techniques, physical activities)

- 1.
- 2.
- 3.

**2 People that provide distraction:** (name, relationship, phone number)

- 1.
- 2.

**2 Settings that provide distraction:** (physical spaces that you enjoy being)

- 1.
- 2.

**Ethos Location:**

- Emmaus: 3835 Chestnut Street Emmaus PA 18049 Fax: (570) 392-6143 Phone: 484-232-5288
- Lehighton: 428 South 7th Street Lehighton PA 18235 Fax: (570) 392-6143 Phone: 610-900-4234

**Medication Management Provider:** (if applicable)

Name:

Address:

Phone:

Fax:

**Therapist:** (if applicable)

Name:

Address:

Phone:

Fax:

**External treatment team providers (ICM, CPS, PO, etc.):** (if applicable)

Name:

Address:

Phone:

Fax:

Name:

Address:

Phone:

Fax:

**Crisis Resources:**

- **Suicide Prevention Hotline 1-800-273-8255**
- **MH Warm Line (866) 854-8114**
- **Suicide Prevention Text Services: text 741741**
- **<https://suicidepreventionlifeline.org/>**
- **<http://www.yourlifeyourvoice.org>**

**2 ways that I can make my environment safe:** (ways to reduce symptoms)

1.

2.

**Protective Factor:** (The 1 thing that is most important to me and worth living for is)

1.

2.

Patient or Legal Guardian:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



**HIPAA Contact Release Form**

In order for us to stay within guidelines of HIPAA, please list below any person/persons that you authorize us to disclose information to regarding you Protect Health Information, including billing information.

Name	Relationship	Phone
1 _____	_____	_____
2 _____	_____	_____
3 _____	_____	_____
4 _____	_____	_____

I understand that I may rescind permission at any time by notifying the office.

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient's Signature (or Guardian)

\_\_\_\_\_  
Date





**Ethos Clinic**

3835 Chestnut St.

Emmaus, PA 18049

Phone: (484) 232-5288 Fax: (570) 392-6143

**Authorization To Release/Obtain Health Information**

I, PATIENT NAME (DOB: PATIENT BIRTHDAY), hereby authorize ETHOS to release/obtain information from Medical records pertinent to the Mental Health/Mental Retardation; Drug/Alcohol treatment; and or HIV/AIDS treatment of: PATIENT NAME.

(Individual's Name)

ROI Valid from TODAYS DATE until TODAY'S DATE NEXT YEAR, or one year from date signed.

OUTSIDE ENTITY NAME

OUTSIDE ENTITY PHONE #

OUTSIDE ENTITY FAX #

(Name of Person/Organization/Facility obtaining records from)

OUTSIDE ENTITY FULL ADDRESS

(Address)

The information which may be released is limited to the MOST RECENT:

Discharge Summary

Blood work

Psychiatric Assessment

X Other

Medication Log

The purpose or need for such disclosure is: COORDINATION OF CARE or CONTINUITY OF CARE

Behavioral Health services may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign authorization except if my treatment is related to research or if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Hereby release Behavioral Health Services and all other persons or legal entities of facilities, related in any way to the release of said information from all responsibility and liability for acting upon this authorization and I intend to be legally bound hereby.

Individual, Parent, Legal Guardian Signature: AGE 14+ PATIENT SIGNATURE Date DATE

Personal Representative Signature 0-13= LEGAL GUARDIAN SIGNATURE or POA if applicable Date DATE

Witness/Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

If any person physically unable to provide a signature desires to consent to this release, print his/her name on the appropriate signature line above and record below the signature of two responsible persons who witness that such a person understand the nature of this release and freely gave his/her consent.

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_



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Emmaus  
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Emmaus, PA 18049  
P: (484) 232-5288

F: (570) 392-6143

### Authorization To Release/Obtain Health Information

I, \_\_\_\_\_ (DOB: \_\_\_\_\_), hereby authorize **ETHOS CLINIC** to release/obtain information from Medical records pertinent to the Mental Health/Mental Retardation; Drug/Alcohol treatment; and or HIV/AIDS treatment of: \_\_\_\_\_.

(Individual's Name)

ROI Valid from \_\_\_\_\_ until \_\_\_\_\_, or one year from date signed.

\_\_\_\_\_  
(Name of Person/Organization/Facility obtaining records from)

\_\_\_\_\_  
(Address)

The information which may be released is limited to the **MOST RECENT:**

\_\_\_\_\_ Discharge Summary

\_\_\_\_\_ Blood work

\_\_\_\_\_ Psychiatric Assessment

\_\_\_\_\_ Other

\_\_\_\_\_ Medication Log

\_\_\_\_\_

The purpose or need for such disclosure is: **CONTINUITY OF CARE**. Behavioral Health services may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign authorization except if my treatment is related to research or if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

Hereby release Behavioral Health Services and all other persons or legal entities of facilities, related in any way to the release of said information from all responsibility and liability for acting upon this authorization and I intend to be legally bound hereby.

Individual, Parent, Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Personal Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness/Staff Member Signature \_\_\_\_\_ Date \_\_\_\_\_

If any person physically unable to provide a signature desires to consent to this release, print his/her name on the appropriate signature line above and record below the signature of two responsible persons who witness that such a person understand the nature of this release and freely gave his/her consent.

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_