RECORD OF ACCESS

DATE	NAME	TITLE	PURPOSE

Advance Directives Acknowledgement Form

It is your right to have a written direction about their mental/health treatment, known as an advanced directive, if you ever lose your ability to make decisions. This plan basically describes how you want to be cared for in case you ever become unable to decide or speak for yourself. You also have the right to revoke the consent at any time.

You may also include a "health-Care Proxy". This lets you name another person to make decisions about your care if you become unable to do so. For assistance preparing these plans, we recommend that you speak to someone you trust. For example, one of our agency staff, a family member or a minister. If you choose through informed consent, the LMHP will further explain available community-based resources for the completion of an advance directive. You may also contact an advocacy agency for assistant and/or support in completing an advanced directive. The following is advocacy contact information:

The Advocacy Center: (800) 711-1696
or
visit the website for a center in your area at www.dhh.louisiana

The agency has explained what advance directive is and its purpose. I understand the plan and at this time I am signing this acknowledgement form and also choose:

__ I do not have an advance directive at this time and not interested; therefore **"I Refuse".**

__ I wish to speak to the LMHP to gain a better understanding of advanced directives and receive a list of community-based resources.

__ I wish to speak to other advocacy agencies or family members about my advance directive plan.

_____ _____
Client or Legally Responsible Name Date

_____ _____
Agency Representative Date

CONSENT FOR TREATMENT

In signing this document, I am stating that I have read and agree to the following conditions regarding services rendered by INSERT AGENCY NAME:

1. I consent to and authorize treatment through Agency's Name
2. I authorize the collection of necessary administrative dates regarding me. I understand that such data shall be computerized for statistical, programming, and billing purposes.
3. I understand information regarding me shall be collect responsibility and maintained in a confidential clinical record. Any such records or information shall remain confidential except in the following incidences:
   a. Information required by third party payers and parties giving AGENCY'S NAME authorization to provide said services shall be forwarded to them.
   b. Records shall be open to AGENCY NAME**:** as needed and to appropriate state mental health officials.
   c. Information may be exchanged if I sign a written release form indicating the nature of information to be released.
   d. Information, which indicates a severe threat to the life or safety or another person or to self, shall be forwarded to the threatened parties or appropriate agencies to the extent necessary to protect life and safety.
   e. Information will be released if required under a court subpoena.
   f. Suspected abuse, neglect or exploitation shall be thoroughly investigated, documented and reported as indicated in agency's policies and procedures.
   g. State and Federal law prohibits the disclosure of any information identifying a Recipient as receiving alcohol/drug services unless the Recipient consents in writing, the disclosure is allowed by court order, disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluations.
   h. Federal Law does not protect any information about a crime committed by a Recipient either at the program or against any person who works for the program or about any threat to commit such a crime.
4. I understand that all services will be provided regardless of gender, color, national origin, sexual orientation, religious preference, and a level of disability.
5. If there is a medical or psychiatric emergency, I give permission for staff to seek emergency care on my behalf.
6. Agency's Name staff may share information with my consent with other associated facilities such as group homes, Dept. of Social Services, Court Services, and Area Programs if a Recipient is seen in two or more of these agencies.
7. I agree to satisfy my financial obligation with AGENCY NAME**:** I understand payment is due at the time services are rendered unless payment arrangements are made.

I understand that I will be receiving the following services provided by AGENCY NAME:

☐ Assessment/ Re-assessment/Treatment Planning
☐ Community Psychiatric Support Treatment
☐ PSR/ Individual
☐ PSR Group
☐ Psychiatric Evaluation
☐ Medication Management
☐ Individual and/or family Psychotherapy
☐ Other:

_____ _____

Recipient or Legal Guardian Signature & Date Agency's Staff Signature & Date

Expiration Date_____

CONSENT FOR TREATMENT

I, _____, give my permission to receive counseling/therapy and other relevant services indicated below from ADD AGENCY'S INFORMATION . I understand that by giving my permission to receive services***, I have the right to withdraw my consent at any time***. Withdrawal of my consent will result in my file being closed immediately. By giving my permission to receive services, I understand that I, as a client, have the right to confidentiality, the right to privileged communication, responsibilities I must uphold as a client and the right to refuse service at any time. I understand that I, as a client, have the right to give informed consent to individuals, agencies, and/or organizations to view my file. I understand that I, as a client, have the right to request, in writing, information in my file at any time.

By signing below, I am agreeing that I have read and understand the above information and agree to the following services:

____ Assessment ____ PSR Group

____ CPST ____ Psychotherapy

____PSR ____ Psychiatric Evaluation

____ Medication Management ____ Other _____

_____ _____

Signature of Recipient or Parent/Legal Guardian Date

_____ _____

Agency Representative Date

Consent to Treatment will expire (annual update): _____

CONSENT TO RELASE OR OBTAIN INFORMATION

Last Name:	Date of Birth:
First Name:	Social Security #:

Address: City/State/Zip:	
I _____ **request and authorize** I _____ **DECLINE request**.	ADD AGENCY NAME

to ☐ obtain healthcare information or ☐ release healthcare information of the recipient named above from/to:

Name:		
Address:		
City/State/ Zip:	Phone:	Fax:

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates:

☐ Clinical Evaluation	☐ Psychological Evaluation	☐ Psychiatric Evaluation
☐ Social History	☐ Medical History, Examination, Reports	☐ Discharge Summary
☐ Laboratory Results	☐ Quarterly Summary	☐ Treatment Plan
☐ Doctor's Progress Notes	☐ Pharmacy Notes	☐ Other _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records.
☐Alcoholism Drug Abuse ☐ Mental Health ☐☐Vocational Rehabilitation☐ HIV (AIDS) ☐ Sexually Transmitted Diseases
☐ Genetics ☐ Psychotherapy Notes ☐ Other: (Specify)_____

This authorization shall expire on _____ (date or event) and is needed for the period beginning _____ and ending _____.

This consent is subject to written revocation at any time except to the extent that action has already been taken in reliance upon this consent. This authorization shall expire on _____ (date or event). I understand that if I do not specify an expiration date/event, this authorization shall expire upon discharged from services.

I understand that the treatment/services are not contingent upon my signing or not signing this authorization. I freely and voluntarily give my authorization for the release of information from my health record. I also understand and authorize that this information may be sent via facsimile transmission.

I agree to this authorization to release and obtain information. I further understand that I can REVOKE this authorization at any time.

TO PARTIES RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42 CFR, Part 2) prohibit you from making further disclosures of it without specific written consent of the person to whom it pertains. A general authorization for the release of health or other information is not sufficient for this purpose**.**

Recipient / Legally Responsible Person Signature:	Date Signed:
Signature/Title of Agency Representative	Date Signed: