Maine Behavioral Healthcare

Shared Electronic Health Record

IDENTIFICATION (NAME AND DOB)

CONSENT TO OUTPATIENT MENTAL HEALTH SERVICES

I. CONSENT TO TREAT

I,_____, am presenting myself, or am being presented by,_____, my authorized representative (indicate relationship):_____, for evaluation and/or treatment of a mental health condition on an outpatient basis. I hereby consent to and authorize the community based program, outpatient clinic or practice, its health care practitioners and personnel, including members of its medical staff, and others involved in my care, to perform examinations and/or diagnostic tests, procedures and treatments that in their judgment may promote my mental health. I understand that I have the right to refuse any suggested examinations, tests or treatment.

1. Purpose, Nature and Benefits of Treatment

This outpatient mental health treatment is indicated for evaluation and treatment of my mental health condition and/or substance abuse. I understand that the outpatient treatment proposed by the clinician(s) responsible for this care may consist of counseling, medications and other treatments. I further understand that the anticipated benefit of this treatment is to stabilize and/or improve my mental health.

2. Foreseeable Risks

I understand that the usual and most frequent risks and hazards involved in mental health treatment include: (i) stimulation of unexpected and unpleasant memories of past experiences; (ii) experience of intense or uncomfortable feelings or impulses that seem difficult to control; (iii) being challenged or confronted on a particular issues; (iv) unanticipated changes in you interpersonal relationships with other and how you feel about them; (v) lack of improvement in your condition; and, (vi) increased background checking if you apply for a job that requires a security clearance. I further understand that mental health treatment remains an inexact science and no guarantees can be made regarding outcomes. If medication is prescribed to improve my mental health, I understand that the side effects of such medication will be discussed with me. Special risks: _____.

3. Duration of Treatment

The length of treatment for mental health conditions varies among individuals. The clinician(s) involved in this care periodically shall review the anticipated duration of these services with me as part of my individual treatment plan which is part of my confidential medical record. I understand that I will be offered a copy of my individual treatment plan and discharge plan to facilitate my post-discharge care coordination.

4. Alternatives to Outpatient Treatment

The clinician responsible for this care has explained to me that outpatient treatment is the only recommended form of treatment at this time and that hospitalization may be recommended if my condition does not improve. I have been informed that I may seek other forms of treatment at any time, if I so choose.

5. Further Information Regarding Treatment

If I have any questions about my treatment, I understand that in addition to the clinician(s) responsible for my care, I may speak with their supervisor, the program or medical director or designee, or the Chief of Psychiatry.

I understand that physicians in training, including fellows and residents, as well as psychologists, and social workers in training, medical students, nursing students and other trainees acting under the supervision of attending clinicians or supervisory nurses and other professionals, may observe and assist in my diagnosis, treatment and care. I understand that some of my evaluation and care will be provided by clinician(s) and others employed by the community based program, outpatient clinic or practice; some care may be provided by clinician(s) and their assistants in their own private practice. My primary mental health clinician and my other treatment physicians can explain, on request, my options for selecting treating physicians at program, clinic or practice or at another mental health provider.

I understand that photographs and videos may be made and used for the purposes of diagnosis, teaching, and documentation, but that no photo or video that identifies me will otherwise be made public without my specific permission. I also understand that my mental health records also may be used for research or teaching, but that such

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records will be used and handled in such a manner to prevent the public disclosure of any information or images that will identify me.

From time to time, the community based program, outpatient clinic or practice may communicate with you about matters relating to treatment, alternative therapies, health care providers, settings of care, care management and care coordination. The program, clinic or practice may also communicate with you about health-related products or services, health insurance coverage for our services, and our participation in health insurance plans. Otherwise, the program, clinic or practice will obtain your written authorization prior to using your protected health information for marketing of our products and services. In addition, the program, clinic or practice will not sell your protected health information without first obtaining your written authorization, and any such authorization will state that the program, clinic or practice is receiving payment for such information.

This consent for treatment is valid for a period of one (1) year, from the date of signature.

_____	_____	_____
Witness Signature	Patient or Authorized Representative Signature	Date / 24-h Time
_____	_____	_____
Interpreter Printed Name	Interpreter Signature (if available)	Date / 24-h Time

II. USES AND DISCLOSURES OF MENTAL HEALTH INFORMATION

UNDER MAINE LAW, HEALTH PROFESSIONALS AND HOSPITALS MAY DISCLOSE MENTAL HEALTH INFORMATION TO OTHER CAREGIVERS AND INSURERS FOR SPECIFIC AND LIMITED PURPOSES.

The community based program, outpatient clinic or practice, members of its clinical staff and employees may make the following continuing uses and disclosures of information relating to evaluation and treatment of my mental health condition, and such uses and disclosures do not require prior authorization from me:

1. For purposes of diagnosis, treatment, care management or coordination of care to healthcare practitioners, facilities and entities both within and outside of the program, outpatient clinic or practice and MaineHealth organizational affiliates including: (a) my primary care providers and other health care practitioners who have been or may become involved in my care both within and outside the State of Maine; (b) clinical and non-clinical personnel who may now or in the future become involved in the transition of my care between hospitals, medical practices, other health care facilities and home, including care coordination and case management services; (c) my shared electronic health record, which may display medication history, known allergies, diagnoses and problems necessary for the management and coordination of my care; and (d) to complete the responsibilities of such health care practitioners and affiliates or facility in relation to my diagnosis, treatment or care;
2. To individuals, companies and governmental agencies that may be responsible for paying for my care including insurance carriers and their health claim reviewers. This authorization is effective until final payment is received for one (1) year from today (whichever occurs first);
3. To outside organizations that carry out quality improvement and benchmarking functions for my health care providers (I understand that I will not be individually identified in any reports from these organizations.);
4. An oral or written statement relating to the physical condition or mental status may be disclosed to my spouse or next of kin upon proper inquiry and in accordance with an authorization executed by me or my authorized representative; and
5. As otherwise authorized or required by statute, regulation or court order.

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I understand that I have the following options with respect to authorizations for the release of my health information:

- I may request in writing to revoke all or part of these authorizations at any time by notifying the program, outpatient clinic or practice in writing. I understand that the revocation shall not apply to any disclosures made prior to receiving notice of the revocation.
- I may request to review my medical records and refuse to authorize any further disclosure of all or some of the information in them outside of the program, clinic or practice shared electronic health record.
- The refusal or revocation of my authorization to release some or all information may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may choose to opt in to HealthInfoNet (HIN), a state-wide arrangement of healthcare organizations who have agreed to work with each other to make available electronic health information that may be relevant to my care, by completing the paperwork provided to me during the registration process and sending it to HIN at the designated address. In the event of such opt-in, I understand that all of my mental health information will be shared except for psychotherapy notes.
- I may request to have a copy of this form.
- This authorization is effective for one (1) year form the date of signing. I authorize future disclosures to the same individual and /or entities during this time period.

III. SPECIAL AUTHORIZATION OF ALCOHOL/SUBSTANCE ABUSE OR HIV TREATMENT INFORMATION

If I receive treatment by a federally-assisted alcohol or drug abuse diagnosis or treatment program, or if I am diagnosed and treated for HIV infection, then I understand that the community based program, clinic or practice will, when necessary, obtain my specific consent on a separate authorization form to disclose related information outside of the program, clinic or practice.

I understand that limited information relating to the diagnosis and treatment of alcohol or drug abuse or HIV infection will still be available to authorized users as deemed necessary within the shared electronic health record including the problem list, medication list, diagnosis and allergy fields; among the community based program, outpatient clinic or practice's professional staff for the purposes of my diagnosis or treatment; to complete the responsibilities of the health care professionals involved in my diagnosis or treatment; and included in continuity of care documents for transitions of care.

IV. PAYMENT AND/OR ASSIGNMENT OF BENEFITS

I understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third party who is responsible for payment. I also am responsible for those charges not covered by my insurance, such as deductibles, co-pays, or evaluations or treatment that are not included as an insurance benefit. This includes services rendered to me that may not meet medical necessity as defined by my insurance carrier.

I authorize my health insurance carrier(s) or other financially obligated third parties, including Medicare and Medicaid, to pay the costs associated with my evaluation and care directly to the community based program, clinic or practice and members of the Medical Staff involved in my care. I further authorize the program, outpatient clinic or practice to release information relating to the billing and filing of claims for reimbursement for medical care delivered to me to the health care provider responsible for the cost of my care and to ambulance units who transport me to the hospital or one of its affiliates, if applicable.

By signing below, I authorize the use and disclosure of health care information for payment purposes. I understand that this authorization will remain valid for one (1) year, or until payment is received, whichever occurs first.

Witness Signature	Patient or Authorized Representative Signature	Date / 24-h Time
Interpreter Printed Name	Interpreter Signature (if available)	Date / 24-h Time