WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM
ADMINISTRATIVE MANUAL

Chapter:	Section:	Subject:
2	5	1

CHAPTER: Board Services and Program Administration		
SECTION: Informed Consent Pertaining to CMH Services		
SUBJECT: General Policy		
Administrative Approval:	Date of Governing Board Action: 2/20/96	Page 1 of 6

I. **PURPOSE:** To establish policy and procedures for obtaining consent pertaining to CMH services.

II. **APPLICATION:** All mental health programs and services operated by the West Michigan Community Mental Health Governing Body.

III. **REQUIRED BY:** Department of Community Health Administrative Rule 330.7003, the Michigan Mental Health Code 330.1724, Accrediting Bodies, and the Mental Health Manual.

IV. **DEFINITIONS:**

Informed Consent: An agreement in writing executed by the person served, his/her guardian if empowered to execute a consent, or his/her parents if he/she is a minor. It implies the following:

- Comprehension: Requires the ability of an individual to understand rationally what the personal implications of providing consent will be based on the nature of a procedure, potential risks, consequences, and other relevant information.

- Knowledge: An individual providing consent to treatment must have basic information about the procedure(s), risks, other related consequences, and other relevant information. The standard governing required disclosure by a doctor is what an individual needs to know in order to make an informed decision. Other relevant information includes all of the following: (i) The purpose of the procedure(s); (ii) A description of any attendant discomforts, potential risks, and benefits that can be reasonably expected; (iii) A disclosure of appropriate alternatives advantageous to the individual, and (iv) An offer to answer further inquiries.

- Voluntariness: There shall be free power of choice without the intervention of an element of force, fraud, deceit, duress, overreaching, or other ulterior form of constraint or coercion, including promises or assurances of privileges or freedom. There shall be an instruction that an individual is free to withdraw consent and to discontinue participation or activity at any time without prejudice to the individual.

- Photography: The use of still, motion pictures, or videotape cameras.

V. **POLICY:** It is the policy of West Michigan Community Mental Health that informed consent be obtained prior to implementing the following:

1.1 Receiving behavioral health services;

1.2 Photographing, audiotaping, videotaping and/or using one-way observation vision mirrors;

1.3 Disclosing confidential information which requires consent; and

1.4 Prescribing medications.

1.5 Providing emergency evaluations at an offsite location.

VI. **PROCEDURES:**

1. Informed Consent authorizations shall include an explanation that the person providing consent may voluntarily revoke the consent at any time without prejudice to the individual.

2. During the request for service process (and annually thereafter) the individual, his/her guardian, or a parent of a minor shall sign a Consent and Agreement to Pay for Services (WMCMH Form #CR001).

   2.1 The individual consenting shall be aware of the procedures, risks, other consequences and relevant information.

3. A minor 14 years of age or older may request and receive mental health services and CMH clinicians may provide services on an outpatient basis (excluding pregnancy termination referral services and use of psychotropic drugs) without the consent or knowledge of the minor's parent, guardian or person in loco parentis. The minor's parent, guardian or person in loco parentis may be informed under the following conditions:

   3.1 If the clinician determines that there is a compelling need for disclosure based upon substantiated probability of harm to the minor or another; however the clinician shall notify the minor of his/her intent to inform.

   3.2 If the minor has received 12 sessions or has been receiving services for four (4) months, the clinician shall either terminate services or notify the minor's parent, guardian or person in loco parentis with the minor's consent to provide further outpatient services.

4. During the course of treatment, the Care Manager or a Service Entry clinician shall determine if the individual is able to understand the nature of a procedure/service, potential risk, consequences and other relevant information for which the individual is seeking.

   4.1 If it is determined that the individual is unable to understand the above areas, then the Care Manager or the Service Entry clinician shall take the necessary steps to petition the court for guardianship.

   4.2 The Care Manager or the Service Entry clinician shall only petition the court for guardianship in those areas where assistance is needed.

5. Prior to photographing, videotaping, audiotaping, and/or using 1-way glass, the Care Manager or designee shall obtain prior written consent from one of the following: (a) The individual if 18 years of age or over and competent to consent. (b) The guardian of the individual if the guardian is legally empowered to execute such consent. (c) The parent with legal and physical custody of the individual if less than 18 years of age.

   5.1 Photographing, videotaping, audiotaping, and/or using one-way vision mirrors may be used in order to:

      5.1.1 Determine the name of an individual; or,

      5.1.2 Provide services, including research to an individual; or,

      5.1.3 Provide educational or for training purposes which includes:

         - Reviewing the effectiveness of the clinical treatment.
         - Providing an objective self-critique of the individual's demeanor to be used in teaching ADL skills, interviewing skills, etc.
         - Providing public awareness of mental health services.

      5.1.4 A photograph of an individual for information or purely personal or social purposes shall not be taken or used if the individual has indicated his or her objection.

5.2 Photographs taken to assist in identifying the individual shall also become a part of his/her clinical record. If a copy of a photograph is given to others to assist in determining the name/identity of an individual (e.g. law enforcement) the photograph shall be returned to the Clinical Records Specialist and kept a part of the individual's clinical record. In addition, the Clinical Records Specialist shall inform the outside party that the copy of the photograph is to be returned together with copies that were made to WMCMH once the name/identity of the individual is determined. Please refer to Policy Chapter 7: HIPPA, Section 1: General Policy, Appendix 7.1.1.12 Audiovisual Recording Procedure.

5.21 The Care Manager shall document in the individual's clinical record using a progress note; the need for making a copy of the individual's photograph. The Care Manager shall also document in the individual's clinical record the date the photograph was given to the outside party and the date the copy of the photograph was returned to WMCMH.

5.22 Photographs or audiotapes in the record of an individual served, and any copies of them, shall be given to the individual or destroyed when they are no longer essential in order to achieve one of the objectives set forth in subsection (5), or upon discharge of the individual, whichever occurs first.

6. WMCMH staff members shall have the individual, his/her guardian or a parent of a minor child sign a Consent to Share Health Information (DCH #3927) prior to disclosing information to outside agencies. WMCMH staff members shall also follow the procedures set forth in the Release of Person Served Information Policy (Chapter Five, Section Two, Subject 1.2).

7. The Care Manger and/or Health Services Team staff shall have the individual, his/her guardian or parent of a minor child sign a Consent for Medication Treatment. (Refer to the Medication Services General Policy Chapter Two, Section Ten, Subject One, and Agency Procedures for Accessing Medication Services Chapter Two, Section Ten, Subject Two for detailed procedures).

8. If an individual, his/her guardian or a parent of a minor child revokes a consent, the request can be verbal or in writing to the Care Manager, front desk staff or clinical records specialist. The Care Manager shall document the verbal or written revocation in a progress note. The care manager shall discontinue the procedures or services to which consent was originally provided except in unusual circumstances, such as a court order for treatment.

9. Persons who present at the ED or jail, after hours and require an emergency evaluation, will sign the Consent for Emergency Off-site Evaluation (CR#011) when their condition allows.

10. Individuals ordered by a court of law to receive mental health services on an involuntary basis represent a special classification. An informed consent for services need not be obtained prior to providing service, but efforts shall always be made to obtain written consent whenever possible before services are initiated.

VII. SUPPORTING DOCUMENTS:

Appendix 2-5-1A: Consent for Photographing or Taping (WMCMH Form CR010)
Appendix 2-5-1B: Verification of Photographs and/or Videotapes (WMCMH Form CR132)
Appendix 2-5-1C: Appendix 7.1.1.12 Audiovisual Recording Procedure
Appendix 2-5-1D: Consent and Agreement to Pay (WMCMH Form CR001)
Appendix 2-10-2E: Consent for Medication Treatment Form (WMCMH Form CR008)
Appendix 2-2-2F: Consent to Share Health Information (DCH #3927)
Appendix 2-5-1E: Consent for Emergency Off-site Evaluation (WMCMH Form CR#011)

Appendix 2-5-1A

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM

CONSENT FOR VIDEOTAPING, AUDIOVISUAL AID AND PHOTOGRAPHING

CUSTOMER NAME:	**CASE #:**

I authorize, for ☐ **myself** ☐ **my child** ☐ **my ward,** the staff of West Michigan Community Mental Health System and _____ (facility name) to make and use the following:

☐ **Photograph** ☐ **Audiotape** ☐ **Videotape** ☐ **Other:** _____

I understand that the above recordings of my image and/or voice will be used for the following purposes:

☐ **Internal Purposes:** To be presented within this agency for educational, research and/or therapeutic use.

☐ **External Use:** **To be presented to:**

Specify to Whom:	
Specify Where:	
Specify Date:	

☐ **I approve of the use of the customer's full name by the news media.**

☐ **I do not approve of the use of the customer's full name by the news media.**

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This authorization is fully understood and is made voluntarily on my part.

Customer or Guardian Signature Date

_____ _____

WMCMHS Translator Signature (If applicable) Date

_____

Public News Agency Representative Signature Date

_____ _____

WMCMHS Representative Signature Date

Appendix 2-5-1B

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM

VERIFICATION OF PHOTOGRAPHS AND/OR VIDEOTAPES

CONSUMER'S NAME:_____ CASE #:_____ DATE:_____

The following photographs and/or videotapes were destroyed or given to the consumer:

NAME OF PHOTOGRAPH AND/OR VIDEOTAPE	VIDEOTAPE	PHOTOGRAPH	DESTROYED	GIVEN TO THE CONSUMER

_____

Clinical Records Technician Signature Date

WMCMHS Form CR132 (6-27-06)

Audiovisual Recording Security Procedure Assumptions

These Audiovisual Recording Security Procedures are based on the following assumptions:

 Audiovisual Recording can, in certain instances, provide opportunities for direct supervision of consumer care and support enhancing quality of services delivered.

 Use of Audiovisual Recording can aid for better diagnosis and treatment than traditional referrals and consultations by enhancing ability of clinical supervisors to review entire sessions and provide feedback derived from direct observation.

 Audiovisual Recording carries with it the risks inherent in any collection, transmission, storage, and/or destruction of health information, such as loss of data integrity, availability, and confidentiality.

 Audiovisual Recording will be utilized by WMCMH employees and/or employees under contract with WMCMH and WMCMH customers.

 Audiovisual Recording will occur only in the context of a written consent from the consumer and with written supervisor authorization to use these devices for the purpose of enhancing care and/or providing supervision.

Procedure

West Michigan CMH will practice Audiovisual Recording in appropriate cases only in accordance with the law, medical ethics, and accreditation requirements. All personnel involved in Audiovisual Recording must take the following actions:

 Safeguard the privacy and confidentiality of customers involved in Audiovisual Recording

 Audiovisual Recording will only occur for customers within West Michigan CMH facilities

 Ensure the physical environment is secure when Audiovisual Recording is occurring and ensure that all participants have signed the WMCMH Consent for Videotaping, Audiovisual aid, and Photographing (Form CRO10).

 Audiovisual Recordings may be shared with other entities for the purpose of supervision and training only if a Business Associates Agreement is in place

 All sharing of Audiovisual recordings with a Business Associate must comply with existing WMCMH Device and Media Controls Procedures and the Security of Electronically Stored Clinical Information Policy

 Ensure that each customer's data is removed from the device when the Audiovisual Recording involving that customer is completed.

 All Audiovisual Recording materials will be disposed of in compliance with the WMCMH Destruction Procedure

 Videotapes or other media involved will not be utilized during video conferencing.

 Report any violations of this Audiovisual Recording Security Procedure in accordance with West Michigan CMH Report Procedure.

Individuals in the following roles at WMCMH have the following responsibilities relative to Audiovisual Recording for delivery of healthcare services:

Clinical Director:

 Ensure that Procedures for Clinical Oversite Committee detail the requirements for the practice of Audiovisual Recording, including guidelines for routine and emergency use of Audiovisual Recording.

 Ensure the attending clinician obtains written informed consent to practice Audiovisual Recording (Form CRO10). The consent must give the customer all information that will enable the customer to evaluate knowledgeably the options available and the risks inherent in the practice of Audiovisual Recording.

Clinical Records Coordinator

 Ensure that WMCMH Consent for Videotaping, Audiovisual aid, and Photographing (Form CRO10) are signed by all parties and are made part of the clinical record.

 Work with Information Systems Coordinator to ensure that Audiovisual Recording communications are secure and protected from breaches of confidentiality.

 Maintain required Audiovisual Recording confidentiality documents, such as consents, in accordance with West Michigan CMH Retention and Destruction Policies.

Information Systems Coordinator

 Establish audiovisual links and storage mechanisms and train staff.

 Perform necessary Audiovisual Recording information asset maintenance.

 Audit Audiovisual Recording for data integrity and for compliance and maintain documentation in accordance with West Michigan CMH policies and procedures.

 Test and revise Audiovisual Recording procedures.

 Maintain documentation of Audiovisual Recording security measures in accordance with West Michigan CMH Retention and Destruction Policies.

Approved by the HIPAA Workgroup 04/06/05 cr; Reviewed & Revised 1/22/15 T. Bonstell

Appendix 2-5-1D

WEST MICHIGAN COMMUNITY MENTAL HEALTH
CONSENT AND AGREEMENT TO PAY FOR SERVICES

☐ **ADULT** ☐ **DEPENDENT**
☐ Initial _____ ☐ Update _____ ☐ Annual _____
While completing this form, if you have questions or need assistance, please see the front desk.

NAME OF PERSON SERVED: _____

ADDRESS: _____

_____
How long has person served lived at this address? _____

Phone #: _____ (Main) _____ (Other)

SEX: ☐ Female ☐ Male **DATE OF BIRTH:** _____

SOCIAL SECURITY #: _____ ☐ Do Not Have ☐ Refused

Did someone refer the person served to us? ☐ No ☐ Yes If yes, please tell us who: _____

CURRENT MARITAL STATUS:

☐ Never Married ☐ Now Married or Cohabiting ☐ Separated ☐ Divorced ☐ Widowed

IS THE PERSON SERVED A VETERAN? ☐No ☐Yes If Yes, dates of service: (from) _____ (to) _____

RACE:

☐ Alaskan Native ☐ American Indian ☐ African American/Black ☐ White ☐ Asian
☐ Other Single Race ☐ 2 or More Races ☐ Native Hawaiian or Other Pacific Islander
☐ Choose Not to Provide

Hispanic or Latino Ethnicity:

☐ Puerto Rican ☐ Mexican ☐ Cuban ☐ Other Specified Hispanic or Latino
☐ Not of Hispanic or Latino Origin ☐ Hispanic or Latino – Specific Origin Not Specified ☐ Unknown

What is the primary language of the person served? ☐ English ☐ Spanish ☐ Other: _____

CARE MANAGER: _____

MEDICAID ENROLLEE: As part of your Medicaid Assistance application form with The Michigan Department of Human Services process, in order to maintain quality health care, we are required by law to share necessary information with Medicaid health plans, programs and providers that deliver health care to you in order to manage and coordinate health care and benefits. This information may include when applicable, information relative to HIV, ARC, AIDS and other communicable diseases. For alcohol and other drug programs we are required to comply with the federal confidentiality law 42CFR Part 2.

Primary Care Physician:_____

Address:_____ **Phone**:_____

EDUCATION: What grade are you **currently** in? _____ (1-12)

Current education status or highest school grade completed for those no longer attending school:
☐ No Schooling or Less than One School Grade ☐ Nursery School, Pre-School or Head Start
☐ Kindergarten ☐ Self Contained Special Education ☐ GED/HS Diploma
☐ 1 Year of College/University ☐ 2 Years of College/University or Associate Degree ☐ Vocational School
☐ 3 Years of College/University ☐ 4 Years of College/University or Bachelor's Degree ☐ Graduate or Professional School ☐ Completed Less than High School-Last Grade Completed_____ (1-12)
Mainstream Special Education Status: ☐ Yes ☐ No

School Attendance Status:
☐ Yes, Individual has attended in last 3 months ☐ No, Individual has not attended in last 3 months
☐ Not Applicable, person served is not aged 3-17 or aged 18-21 and protected by IDEA

PERSON SERVED EMPLOYMENT STATUS:

☐ Full-Time (35+ hours/week) ☐ Part-Time (<35 hours/week) ☐ Not in Competitive Work Force
☐ Unemployed (looked during the last 30 days, or on job layoff) ☐ NA (Individual is under 16 years old)

Detailed Not In Competitive Integrated Labor Force: ☐Homemaker ☐ Student ☐ Retired
☐ Discouraged Worker ☐ Micro-Enterprise ☐ Unpaid volunteering, community service, etc.
☐ Individual's current disability symptoms prevents him/her from competitively or non-competitively working or seeking work ☐Receiving services from institutional facility such as hospital, jail, prison, long-term residential
Participates in: ☐Sheltered Workshop ☐ Enclave, mobile crew, or agency funded transitional employment
☐ Facility-based activity program where any array of specialty supports and services are provided to assist an individual in achieving her/his non-work related goals.

LIVING ARRANGEMENT OF PERSON SERVED:

☐ Homeless ☐ Private Residence NOT OWNED by the PIHP, MCMHSP or Contracted Provider
☐ Residential Care/AFC ☐ Foster Home/Foster Care ☐ Crisis Residential ☐ Institutional Setting
☐ Private Residence Owned by CMH/Contract Provider ☐ Private Residence with Natural/Adoptive Family ☐ Jail/Correctional Facility/Other Criminal Justice Institution

Detailed Residential Care Living: ☐ Specialized Residential Home – includes any foster care facility
☐Specialized Residential or Licensed Children's Therapeutic Group Home
☐ General Residential Home – Licensed Foster Care or Facility NOT certified to provide specialized program

IS PERSON SERVED OR AN IMMEDIATE FAMILY MEMBER RECEIVING SERVICES FROM ANOTHER HUMAN SERVICES AGENCY? ☐ No ☐ Yes If yes, check all that apply:
☐ DHHS Department of Health & Human Services ☐ Child and Family Services ☐ Catholic Charities
☐ Public Health ☐ Private Therapy Services ☐ Juvenile Court ☐ Wraparound Services ☐ AA/NA
☐ Bethany Christian Services ☐ Lutheran Social Services ☐ Other: _____

IS PERSON SERVED CURRENTLY EXPERIENCING LEGAL PROBLEMS?
☐ In Prison ☐ In Jail ☐ Paroled from State/Federal Correctional Facility ☐ Probation ☐ Tether
☐ Juvenile Detention Center ☐ Post Booking Diversion ☐ Booking Diversion
☐ Pre-Trial (Adult)/Preliminary Hearing (Youth) ☐ Pre-Sentencing (Adult)/Pre-Disposition (Youth)
☐ Not under the jurisdiction of corrections or law enforcement program

Total Annual Income: $_____ ☐ SDA/SSI/SSDI Enrolled
Is person served earing minimum wage or more? ☐ Yes ☐ No
Number of Dependents supported by income and/or children under the age of 18:_____

☐ **PARENT (if recipient is a minor)** ☐ **GUARDIAN/CONSERVATOR (if applicable) And/or**
☐ **EMERGENCY CONTACT INFORMATION (If applicable)** ☐ **NA**

Marital Status of Parent/Guardian (if recipient is a minor):
☐ Never Married ☐ Now Married or Cohabiting ☐ Separated ☐ Divorced ☐ Widowed

Name: _____ **Relationship:** _____
Phone #: _____ **Social Security #:**_____
Address: _____

Name: _____ **Relationship:** _____
Phone #: _____ **Social Security #:**_____
Address: _____

Who has Legal Custody/Guardianship and type? _____
Is this ☐ Shared or ☐ Full Legal Custody ☐ NA

PAYMENT POLICY: Payment is due at the time of service. As a means of containing our costs and your charges, we ask that you come to the office prepared to pay.

ASSIGNMENT OF BENEFITS AND CONSENT TO BILL INSURANCE

The insurance company(s) has been called to verify coverage. **They did not guarantee payment.** They did indicate they might pay a percentage for services once the deductible has been met. If the insurance company does not pay, the person served/guardian will be responsible for payment. WMCMH is authorized to release any and all appropriate information that may be required by said insurance companies for the payment of any claims submitted regarding the person served. Assignment has been made to WMCMH for all rights to any insurance proceeds, which are entitled. Person served/guardian will turn over to WMCMH any money paid directly to the insured from insurance company for services.

CONSENT FOR SERVICES: I understand that by **checking (√) "yes"** in the box below, it means that I agree to care, which may include consultation service, off-site evaluations, or care in case of a medical emergency for: ☐ **Myself** ☐ **My Dependent** from West Michigan Community Mental Health. I understand that if an off-site evaluation or consultation is needed, I will be told the name of the provider, the reason for the evaluation and be told about the confidentiality policy of the West Michigan Community Mental Health. In case of a medical emergency I give permission for WMCMH to obtain whatever treatment may be deemed necessary. I also will hold harmless WMCMH against any liability caused by their

taking of any emergency procedures and/or contacts. I will assume full responsibility of all incurred emergency treatment expenses. ☐ **Yes** ☐ **No**

RIGHTS AND RESPONSIBILITIES OF PERSONS SERVED:

☐**I have been offered/received the following:**

- ✓ Verbal and written information about the rights of persons served, together with the **Rights and Confidentiality of Alcohol & Drug Abuse Information** while getting services from WMCMH, including my right to make a complaint.
- ✓ Medicaid/CMH member handbook.
- ✓ **I**nformation about Advance Directives
- ✓ A copy of the WMCMH Privacy Notice

☐ I authorize WMCMH to phone my main and/or other phone number and leave a reminder message for my appointments. ****WMCMH reserves the rights to send correspondence to your mailing address unless you specifically indicate you do not want correspondence sent to your mailing address and provide a reasonable address or method of contact** (notification of guardian is required.)

If applicable, is it okay to confirm appointments for transportation reimbursement purposes? ☐ Yes ☐ No ☐ NA

DURABLE POWER OF ATTORNEY/ADVANCE MEDICAL DIRECTIVES: In complying with Michigan Department of Mental Health procedures, it is required that all persons served be questioned as to the existence of an "advance directive" and durable power of attorney for medical care. Have you/person served ever signed a durable power of attorney document specifying your directions as to medical care of the withholding of medical procedures for certain health conditions? ☐ **Yes** ☐ **No** ☐ **Does Not Apply**

Name: _____**Phone:**_____

Address: _____

CONSENT TO TRAVEL AND/OR LEAVE WMCMH BUILDINGS: I understand that by **checking (√) "yes"** in the box below, it means that I am giving permission for: ☐ **myself** ☐ **my dependent**, to travel and/or be taken out of the office or program, as needed in order to get care from WMCMH. I will not hold the WMCMH, or its agents, responsible for any injuries and/or damages that may occur while traveling to, or participating in, an organized event that requires travel away from the office or program. ☐ **Yes** ☐ **No** ☐ **Does Not Apply**

☐ I give permission for **my dependent/ward** to be released, with proper identification, to the person(s) listed below. ☐ **NA**

Name: _____**Relationship:**_____

Name: _____**Relationship:**_____

X_____ _____

Signature of Person Served or Guardian Date

_____ _____

WMCMH Staff Signature Date

********FOR UPDATE PURPOSES ONLY**

If a customer re-enters services within 6 months of completing this form, it can be reviewed, approved or changes indicated and resigned and dated.

☐ **I have reviewed this form and all information remains the same.**

☐ **I have reviewed this form and have identified changes above.**

Additional Comments:

********FOR UPDATE PURPOSES ONLY**

X _____ _____

Signature of Person Served or Guardian Date

_____ _____

WMCMH Staff Signature Date

Appendix 2-10-2E

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM
CONSENT FOR MEDICATION TREATMENT

CUSTOMER NAME:	**CASE #:**
DATE:	

I hereby grant consent for: ☐ **myself** ☐ **my child** ☐ **my ward** to receive the following prescribed medication/medications under the supervision of West Michigan Community Mental Health System's physician and staff:

Name of Medication Prescribed	**Average Range**	**Medication Instruction Sheet Provided/Offered**	**Discontinued Date**
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	
		☐	

I certify that the proper use and potential side effects of the above medication/medications have been explained to my satisfaction and that written material has been given to me explaining the proper use and potential side effects of the above medication/medications.

I acknowledge understanding that if the West Michigan Community Mental Health System's physician should change the medication(s), a new medication consent shall be obtained.

I acknowledge understanding that it is the customer's responsibility to attend all scheduled medication review appointments to enable the physician to evaluate the customer's response to medication, and monitor for potential side effects.

I acknowledge that it is my responsibility to notify West Michigan Community Mental Health System and/or physician of any suspected medication side effects.

I understand that I may revoke this consent at any time without prejudice to my further treatment.

This medication consent expires when the WMCMHS physician discontinues medication, or one (1) year from the date it is signed.

Customer or Guardian Signature _____ Date _____

West Michigan CMH System Health Care Professional _____ Date _____

Appendix 2-2-2-F

Consent to Share Health Information
Will be added to policy by records due to security functions

Appendix 2-5-1E

WEST MICHIGAN COMMUNITY MENTAL HEALTH SYSTEM

CONSENT FOR EMERGENCY OFF-SITE EVALUATIONS

CUSTOMER NAME:	**CASE #:**

I agree to have ☐ **myself** ☐ **my child** ☐ **my ward** evaluated as to my/his/her mental health needs.

In regard to this evaluation, I also have been informed of the following: the name of the community agency/service provider requesting the evaluation; identified reasons for the evaluation; that there may be charges incurred with this service; and, confidentiality policies of West Michigan Community Mental Health System.

Customer or Guardian Signature _____ Date _____

WMCMHS Translator Signature (If applicable) _____ Date _____

WMCMHS Staff _____ Date _____

- Attached is a WMCHMS Release of Information authorizing the release of a written evaluation report to:

_____

_____

_____

_____

_____

_____

_____

_____

_____