South Shore Behavioral Health Clinic
CLIENT CONSENT FORM

COUNSELING is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies. It involves a relationship between you and a trained therapist who has the desire and willingness to help you accomplish your individual goals. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable. Your therapist is available to support you throughout the counseling process.

CONFIDENTIALITY:

All interactions with South Shore Behavioral Health Clinic, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are confidential. You may request in writing that the counseling staff release specific information about your counseling to persons you designate.

EXCEPTIONS TO CONFIDENTIALITY:

- The counseling staff works as a team. Your therapist may consult with other counseling staff to provide the best possible care. These consultations are for professional and training purposes.

- If there is evidence of clear and imminent danger of harm to self and/or others, a therapist is legally required to report this information to the authorities responsible for ensuring safety under the "Duty to Warn, Duty to Care Law" MGL Chap 123, sec 36B..

- Massachusetts state law requires that staff of the **South Shore Behavioral Health Clinic** who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to child protection services.

- A court order, issued by a judge, may require the **South Shore Behavioral Health Clinic** staff to release information contained in records and/or require a therapist to testify in a court hearing.

We appreciate prompt arrival for appointments. Please notify us, or your therapist if you will be late. Twenty-four hour notice of cancellation allows us to use the time for others.

I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the South Shore Behavioral Health Clinic

.

_____ _____

Signature of Client *Signature of Therapist*

_____

Date

South Shore Behavioral Health Clinic

Clients Rights, Responsibilities and Consent

Clients Rights

1. **South Shore Behavioral Health Clinic** provides evaluations and counseling by medical health professionals including psychiatrists, psychologists, clinical social workers, psychiatric nurses, and masters level clinicians. As a client you have the right to services which are provided in a professional manner.
2. If you feel that an evaluation was not explained fully, or that psychotherapy is not being provided as agreed upon, please first discuss it with your therapist. If you are not satisfied, you may write or call the Site Director at the site your services are provided.

Clients Responsibilities,

1. Payment of the clinical fee is the responsibility of the client, and is due at the time the service is rendered. Clinical policy prohibits scheduling further appointment when there is an overdue balance.
2. When partial or full payment is available through medical insurance plans, the client may defer payment of part or all of the fee. Any portion of the fee not covered must be paid in *full by* the client at the time the service is rendered.
3. When third party payment is uncertain, as with certain commercial insurance plans, the fee must be paid in full by the client until *the third* party payment is received. Any resulting overpayment will be reimbursed or credited to client's account.
4. Repeated cancellations or no-shows may result in termination of service.

Client Consent and Authorization

- I authorize **South Shore Behavioral Health Clinic** to release information necessary to process insurance claims.
- I authorize **South Shore Behavioral Health Clinic** to provide information to the managed care company (when relevant) for purposes of outpatient services authorization.
- ❑ **I hereby give consent for outpatient treatment and understand that I may rescind this authorization and terminate care at any time, with or without prior notice.**
- *I hereby authorize my* insurance carrier to pay **South Shore Behavioral Health Clinic** directly for services rendered.
- I have received and understand my Clients Rights as contained in Massachusetts General Law, Section 70E of Chapter 111.
- I understand that information about me will be kept confidential and will not be released without my consent except in specific circumstances which have been explained to me. I understand that the primary clinician assigned to my care by **South Shore Behavioral Health Clinic** may discuss that care with other persons employed by or consulting to **South Shore Behavioral Health Clinic** for purposes of supervision, guidance and consultation regarding my care.

Print Name of Client: _____

Client /or Legal Guardian Signature Date

Witness Date

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
OFFICE OF MEDICAID (MASSHEALTH)

PERMISSION TO GET AND SHARE INFORMATION IN THE MASSHEALTH CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS) SYSTEM

Name of MassHealth member (Member) _____

Name of behavioral-health assessor (Assessor) _____

Name of provider organization (Provider) _____

Provider address _____

_____ (Member) is under the age of 21 and is receiving a behavioral health assessment.

What is the CANS?

Behavioral-health providers (providers) use a tool called the Child and Adolescent Needs and Strengths (CANS) to collect behavioral health clinical information about members under 21. For members who are in ongoing treatment, a provider will regularly update the CANS at least every 90 days.

The information collected using the CANS tool (CANS Information) helps providers to do a number of things, such as:

- decide what behavioral health services a member may need
- check over time that behavioral health services are helping the member

Why MassHealth Wants to Obtain and Share CANS Information

MassHealth has a computer system that a provider can use to enter CANS Information each time a behavioral health assessment is done or updated. MassHealth wants to use the system to access CANS Information and share it with providers and MassHealth managed care entities (organizations that manage and pay for a member's care) so that such parties can work together to make sure that the behavioral health services offered to the member meet the member's needs. Sharing CANS Information through the system will also help better inform the member's providers of the member's medical history and reduce the overall amount of information that such providers must collect from the member, as further described below.

If you give your permission, the Provider noted above will enter any CANS Information that it collects about the Member into the MassHealth system. Through this system, MassHealth will be able to access such information and make it available to the Provider for future access. MassHealth will also use the

system to give the Provider access to any CANS Information entered by the Member's other providers. This will allow the Provider to update the Member's CANS Information when needed, rather than redoing the whole CANS again. If you agree, MassHealth will also use the system to give the Member's other providers with permission access to the CANS Information entered by the Provider in the CANS system, so they will understand the Member's history and may not need to ask the Member to repeat as much information. Your permission will also allow MassHealth to use the system to give a MassHealth managed-care entity in which the Member is enrolled access to CANS Information collected by the Provider.

Your Permission

By signing below, you give permission for the Provider listed above to:

- enter all of the CANS Information about the Member that it collects into the MassHealth system
- view and copy any CANS Information about the Member that other providers have entered into the MassHealth CANS system

By signing below, you also give permission for MassHealth to use the system to share CANS Information collected by the Provider with:

- the Provider noted on the first page of this form
- the MassHealth managed-care entity in which the Member is enrolled at the time that the CANS is entered into the MassHealth CANS system
- other providers for whom you have given permission

Things You Should Know

Neither MassHealth nor the Provider may condition treatment, payment, enrollment or eligibility for benefits on whether you sign this form or whether you decide to take back the permission in the future.

If you give your permission to the activities noted above, the Provider will enter CANS Information about the Member into the MassHealth system, and MassHealth will access such information and share it with the Provider, other providers for whom permission is given and the Member's managed-care entity. Your permission will also allow MassHealth to give the Provider access to CANS Information entered into the system by the Member's other providers. **Note that even if you do not provide your permission, MassHealth and the Provider may still use or disclose CANS Information about the Member as required or permitted by law.**

After CANS Information is shared through the MassHealth system, the organization that shared the information will no longer be able to control how it is used or disclosed. The privacy laws covering CANS Information may be different when MassHealth, providers, or managed care entities hold the information, but each such organization must follow the privacy laws that apply to it when using or disclosing the information.

You may put a permission end date on this form below. If you do not, the permission ends one year from when you sign this form.

You may cancel this permission at any time in writing. The cancellation will prevent the Provider and MassHealth from using the MassHealth system to share CANS Information that is collected after you cancel your permission. Information that has already been made available to MassHealth, managed care entities, the Provider or other authorized providers through the MassHealth system prior to receipt of your cancellation cannot be taken back.

The written cancellation must:

- say who the Member is
- give the Member's birth date
- say who you are
- say if you are the Member, the Member's custodial parent, or explain why you can act for the Member
- say that you are cancelling your permission to enter and share CANS Information online

You must give the written cancellation to the Provider at the address noted on the first page of this form. The Provider must then notify MassHealth by emailing a scanned copy of the written cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Your Signature

By signing this permission form, you are giving permission for the uses and disclosures of CANS Information about the Member as noted above. You are also saying: that you have read the whole form and signed it willingly; and that you have the right to get a signed copy of the form.

_____
Printed name of person signing permission

_____
Signature of person signing permission

_____
Date of signing (date permission starts)

_____
Date permission ends (If no date is written on this line, permission will end one year from the date of signing.)

Please check the line below saying why you can sign this permission under law.

_____ I am the Member. I am 18 years old or older. If I am not 18 years old or older, I can give my permission for other reasons under law.

_____ I am the Member's custodial parent.

_____ I am able to act for the member to give permission to give out medical information. I have attached a legal document showing why I can do this.

<u>Reminder to Provider</u>: A signed copy of this form must be given to the Member or caregiver. If the Member or caregiver later cancels this consent, you must e-mail a scanned copy of the cancellation letter to: CANS-CBHI@MassMail.State.MA.US

Instructions

1. Please fill out packets and make sure they are signed, witnessed, and positive identification is attached, along with any guardianship paperwork in the case of a minor child who is in foster care or in the company o a legal guardian.
2. Packets can be returned in the following manner, and must be received within 10 days in order to continue services. For clients with packets not returned within 10 days, services will be paused until packet is received.
   a. Mailed to:
      South Shore Behavioral Health Clinic
      C/O Intake
      200 Cordwainer Drive
      Suite 200
      Norwell, MA 02061
   b. Faxed to:
      Attn: Intake
      (339)788-9904
   c. Securely Emailed to intake@ssbhc.com
      Most email servers are not HIPPA compliant, meaning that information sent via email may be susceptible to data breach and or data loss. This method is not recommended, and may be used at client's own liability. For those choosing to email documents, they must be password protected.

Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health with, _____ , as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right tofuture care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information(PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to to discuss since we may reconnect within ten minutes, please call me at_____ have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
8. South Shore Behavioral Health is providing telemental health services on a temporary basis granted by permission from the Governor of Massachusetts and Massachusetts health insurance companies due to Covid-19. Once these temporary permissions are lifted, all clients wishing to continue services may do so face to face in your home, school, or our office.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____

_____

_____

and my emergency contact person's name, address, phone: _____

_____

_____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian: _____

Date: _____

Signature of witness: _____

Date: _____

Signature of therapist: _____

Date: _____

South Shore Behavioral Health Clinic

Norwell & Lakeville a CARF Accedited Facility

COVID-19 Affidavit and Release of Liability

In our efforts to ensure the safety and wellness of our clients and staff, we want to ensure that those who visit the office (both clients and staff) understand the importance of being healthy and safe. Symptoms of COVID-19 can be mild to severe and can include fever, cough, fatigue, shortness of breath, and digestive symptoms (diarrhea or loss of appetite). Symptoms may appear 2-14 days after exposure. Persons at greater risk include those over the age of 62 or those who have underlying health issues (heart disease, diabetes, respiratory issues, smokers, cancer, or weakened immune system from other underlying causes not listed here).

By signing below, I agree to the following:

1) I understand that I am under no obligation to come into the office.
2) I have not experienced any symptoms of illness including fever, cough, fatigue, shortness of breath, diarrhea, or unexplained loss of appetite in the last 14 days.
3) I have not been ill in the last 14 days.
4) No one in my immediate household have experienced any of the above symptoms or have been ill in the last 14 days.
5) I have not knowingly been exposed to anyone diagnosed with the COVID-19 virus nor currently under quarantine for the virus in the last 14 days.
6) I have not traveled outside of Massachusetts in the last 14 days.
7) If I should begin to feel ill while visiting the office, I will notify a staff member and immediately seek medical help. If diagnosed with COVID-19, I will notify the office so specific steps can be made to quarantine others that may have been affected prior to that diagnosis.
8) I release and hold harmless the South Shore Behavioral Health Clinic (and its staff and clients) of any and all liability if I should develop COVID-19 after visiting the office.

_____ _____

Staff/Client Printed Name Date

_____ _____/_____

Staff/Client Signature Visit time (include approximate start and end time)

_____ _____

Phone Number Email address

_____

Witness

South Shore Behavioral Health Clinic
200 Cordwainer Drive, Suite 200, Norwell, MA. 02061
109 Rhode Island Road, Suite A Lakeville MA 02347
Tel: 781-878-8340

Deductible and Fee Disclosure Agreement

I, _____, agree that I will pay the deductible rate of $75 per session until my insurance deductible has been met, or in the case my insurance is no longer active. I agree that if I am meeting with the psychiatrist I will pay a rate of $150 for the initial appointment and $125 for each subsequent appointment. I understand that my deductible is set by my insurance company, not South Shore Center for Wellness LTD DBA "South Shore Behavioral Health Clinic". I understand that if I am, for any reason, unable to pay the set deductible rate of $75 per session that I will not be able to continue with services until all balances have been paid in full.

Print name of client

Client/Legal Guardian signature Date

Witness signature Date

Intake Checklist and Signature Page

Please Check all boxes when each form is signed, and to verify all forms are in packet

Please Check off and initial the Rights and Policies below. Initial

- ☐ I have read the SSBHC Agency Policy..... ☐
- ☐ I have read the Client Rights..... ☐
- ☐ I have read the Summary of Privacy Practices ..... ☐
- ☐ I have read the deductible agreement..... ☐
- ☐ I have read and consent to treatment at SSBHC..... ☐
- ☐ I have read and consent to SSBHC no show policy..... ☐
- ☐ I have read the informed consent for treatment at SSBHC..... ☐

Client: _____ Date: _____
(print name)

Client/Parent/Guardian: _____ Date: _____
(Signature)

Therapist: _____ Date: _____
(Signature)

I have read all the policies above, and by signing below I acknowledge receipt of copies of the above policies.

Give to Clients

- ☐ SSBHC Agency Policy
- ☐ Summary of Privacy Practices
- ☐ Clients Rights

Place in Client Folder

- ☐ Credit Card Auth (if applicable)
- ☐ Couples Release (if applicable)
- ☐ Consent for Treatment in School setting (if applicable)
- ☐ Deductible Agreement
- ☐ Emergency Contact / Phone List Form
- ☐ Authorization to Obtain/Release PHI (2 sided) MBHP Med Communication Form

South Shore Center for Wellness LTD
DBA South Shore Behavioral Health Clinic
200 Cordwainer Drive Suite 200 Norwell MA 02061
Tel: 781-878-8340

Authorized Phone Numbers to Contact Clients

Home: _____ is it ok to leave message _____ yes _____ No

Work: _____ is it ok to leave message _____ yes _____ No

Cell: _____ is it ok to leave message _____ yes _____ No

Spouse: _____ is it ok to leave message _____ yes _____ No

Texting Number : _____ it is ok to text _____ yes _____ No

Email _____ is it ok to leave message _____ yes _____ No

I _____ hereby authorize you to call the above numbers checked yes to contact me, leave me a voice message, Email, or contact be by Text.

Client: _____ Date : _____

Witness: _____ Date: _____

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:_____ - _____Date of Birth:_____
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____

Print Name of Provider You are asking for records or speak to

Address: _____

Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: South Shore Center for Wellness LTD _____

Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information

Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

My health information may be disclosed under this Authorization to:

To the Recipient: _____

Organization to receive the information Print Name of Individual to receive information

Address: _____

Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

• Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;

• Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (I) this test is ordered, performed, or reported and ([I) the test results are positive or negative.

• Information regarding the results of a genetic test.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:_____Date of Birth: _____
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

_____

❑ Specific health information including only:

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)_____

_____

; or_____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: _____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1._____ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2._____ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3._____ 1 understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. 1 further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_____ Date: _____

Print Full Name of Person Served:_____

Relationship of Representative to Person Served:_____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:_____ - _____Date of Birth:_____
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____

Print Name of Provider You are asking for records or speak to

Address: _____

Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: South Shore Center for Wellness LTD _____

Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information

Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

My health information may be disclosed under this Authorization to:

To the Recipient: _____

Organization to receive the information Print Name of Individual to receive information

Address: _____

Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

• Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;

• Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (I) this test is ordered, performed, or reported and ([I) the test results are positive or negative.

• Information regarding the results of a genetic test.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:_____Date of Birth: _____
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

_____

❑ Specific health information including only:

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)_____

_____

; or_____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: _____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1._____ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2._____ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3._____ 1 understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. 1 further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_____ Date: _____

Print Full Name of Person Served:_____

Relationship of Representative to Person Served:_____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Client:_____ - _____Date of Birth:_____
(Please Print)

South Shore Center for Wellness LTD DBA South Shore Behavioral Health Clinic

SECTION A: USE OR DISCLOSURE OF HEALTH INFORMATION

By signing this Authorization, I authorize the use or disclosure of my individually identifiable health information maintained by: South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061, 109 Rhode Island Road, Lakeville MA 02347

TO OBTAIN INFORMATION FROM ANOTHER ENTITY

From the Provider: _____

Print Name of Provider You are asking for records or speak to

Address: _____

Print Address of Provider

My health information may be disclosed under this Authorization to:

To the Recipient: South Shore Center for Wellness LTD _____

Address: 200 Cordwainer Drive Suite 200 Print Name of Individual to receive information

Norwell MA 02061 Telephone: 781-878-8340

TO RELEASE INFORMATION TO ANOTHER ENTITY

From the Provider: South Shore Center for Wellness LTD

Address: 200 Cordwainer Drive Suite 200, Norwell MA 02061

My health information may be disclosed under this Authorization to:

To the Recipient: _____

Organization to receive the information Print Name of Individual to receive information

Address: _____

Print Address of Recipient Telephone

Health information includes information collected from me or created by the South Shore Center for Wellness LTD. Health information may relate to my past, present or future physical or mental health or condition, the provision of my health care, or payment for my health care services.

Any provider that operates a federally-assisted alcohol or drug abuse program is prohibited from disclosing information about treatment for alcohol or drug abuse without my specific written authorization unless a disclosure is otherwise authorized by federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

I further understand that under state law South Shore Center for Wellness LTD is prohibited from disclosing information about my HIV status without my specific written authorization. South Shore Center for Wellness LTD is also prohibited under state law from disclosing the results of a genetic test (including the identity of a person being tested) without first obtaining an authorization that constitutes "informed written consent", except when the test results disclosed will be used only as confidential research information for use in epidemiological or clinical research conducted for the purpose of generating scientific knowledge about genes or learning about the genetic basis of disease or for developing pharmaceutical and other treatments of disease.

SECTION B: SCOPE OF USE OR DISCLOSURE

Dates of Treatment or Agency Involvement to which Authorization Pertains: Check One:

Health information that may be used or disclosed through this Authorization is as follows:

❑ **All health information about me, including my clinical records, created by South Shore Center for Wellness LTD.**

This information may include, if applicable:

• Information pertaining to the identity, diagnosis, prognosis or treatment for alcohol or drug abuse maintained by a federally-assisted alcohol or drug abuse program; or;

• Information regarding AIDS, ARC or HIV including, for example, a test for the presence of HIV antibodies or antigens, regardless of whether (I) this test is ordered, performed, or reported and ([I) the test results are positive or negative.

• Information regarding the results of a genetic test.

AUTHORIZATION FORM TO OBTAIN/RELEASE PHI

Name of Person Served:_____Date of Birth: _____
(Please Print)

❑ All health information about me as described in the preceding checkbox, excluding the following:

_____

❑ Specific health information including only:

_____

Note: Describe the health information to be excluded or included in a specific and meaningful fashion.

SECTION C: PURPOSE OF THE USE OR DISCLOSURE

The purpose(s) of this Authorization is (are): Check one below:

❑ Specifically, the following purpose(s)_____

_____

; or_____

❑ The request for information to be used or disclosed has been initiated by the Person Served and/or Parent/Guardian and the Person Served and/or Parent/Guardian does not elect to disclose its purpose.

Note: This box may NOT be checked if the information to be used or disclosed pertains to alcohol or drug abuse identity, diagnosis, prognosis or treatment

SECTION D: EXPIRATION *(Note: If an expiration event is used, the event must relate to the Person Served or the purpose of the use or disclosure.)*

This Authorization expires: _____
(Insert applicable event or date - mm/dd/yy)

SECTION E: OTHER IMPORTANT INFORMATION

1._____ I understand that providers cannot guarantee that the Recipient will not redisclose my health information to a third party. The Recipient may not be subject to federal laws governing privacy of health information. However, if the disclosure consists of treatment information about a Person Served in a federally-assisted alcohol or drug abuse program, the Recipient is prohibited under federal law from making any further disclosure of such information unless further disclosure is expressly permitted by written consent of the Person Served or as otherwise permitted under federal law governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR, Part 2).

2._____ I understand that I may refuse to sign this Authorization and that my refusal to sign will not affect my ability to obtain treatment (or payment, if applicable) from South Shore Center for Wellness LTD, except when I am (I) receiving research-related treatment or (II) receiving health care solely for the purpose of creating information for disclosure to a third party. If either of these exceptions apply, my refusal to sign an authorization will result in my not obtaining treatment (or payment, if applicable) from the Provider.

3._____ 1 understand that I may revoke this Authorization in writing at any time, except that the revocation will not have any effect on any action taken by the Provider in reliance on this Authorization before written notice of revocation is received by the Provider. I further understand that that I must provide any notice of revocation in writing to the Privacy Officer at South Shore Center for Wellness LTD. The address of the Privacy Officer is: Privacy Officer, South Shore Center for Wellness LTD 200 Cordwainer Drive, Suite 200 Norwell MA 02061. 1 further understand that additional restriction on the use or disclosure of my PHI must be requested in writing on a form entitled *Person Served Restriction on Uses and Disclosures of PHI for Treatment, Payment or Operations.*

I have read and understand the term of the Authorization. I have had an opportunity to ask questions about the use or disclosure of my health information.

Person Served/Legal Representative Signature:_____ Date: _____

Print Full Name of Person Served:_____

Relationship of Representative to Person Served:_____

(When Person Served is not competent to give consent, the signature of a parent, guardian, health care agent (proxy) or other representative is required.