EXPRESS AND INFORMED CONSENT FOR TREATMENT

Consumer Name: ___________________________________________________________  Client ID: ______________

I, the undersigned, a _____consumer, _____guardian, _____guardian advocate, _____health care surrogate/proxy, hereby authorize the professional staff of this facility to administer substance abuse and/or mental health assessment and treatment.

I understand that I am responsible for fees for services rendered.

I understand that more information will be provided to me before my informed consent will be requested for the administration of psychotropic medications.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

I have received detailed information about the proposed treatment, its purpose, alternative treatments, approximate length of care, and indications and contraindications of the treatment.

I have read and had this information fully explained to me and have had the opportunity to ask questions and receive answers about the treatment.

I understand that my records are confidential, but that there are some exceptions. LifeStream agrees not to release any information about you, other than to LifeStream staff on a need to know basis (clinical supervision, case staffings, consultations, transfers within LifeStream), without getting your permission in writing. Florida and Federal law protects such information. Violations of these regulations may be reported as a crime. However, there are times when the law also says that information must be shared. These include cases where there is physical and sexual abuse or neglect of children, elders, or disabled persons; there is expression of intent to harm self or others; there is a threat or commission of a crime on LifeStream’s premises or to staff; a court order is issued requiring LifeStream to release information; we learn of a contagious disease which may harm others; and/or the State requires that we report consumer data for follow-up study.

Informed Consent for Electronic Messaging   ___ Agree   ___ Disagree

I understand that I must provide written consent, recognizing that email is not a secure form of communication. There is some risk that any protected health information (PHI) that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. I understand that LifeStream staff will use the minimum necessary amount of protected health information to respond to a query and that the initiation of the email exchange will be by the consumer and never LifeStream staff.

I hereby _____GIVE   ____DO NOT GIVE LifeStream permission to contact me.

(We may want to contact you to remind you of appointments or to find out how you are doing during or upon completion of your treatment.)

I hereby _____GIVE   ____DO NOT GIVE permission for the Florida Department of Mental Health and Substance Abuse to contact me for follow up study.

You can call me at (_____) _____-_________  During these times: ________________________________

________________________________________________                _____________________
Signature of Consumer  Date: mo/day/year

________________________________________________    ______________________
Signature of Witness for Consumer  Date: mo/day/year

__________________________________________________    ______________________
Signature of (circle appropriate identifier) Parent/Guardian,
Guardian Advocate, Health Care Surrogate, Health Care Proxy

CONFIDENTIAL AND PRIVILEGED
For Professional Use Only