

CONSENT FOR SERVICES

Name (please print) _____ DOB _____ MHCD ID# _____ Date of Admission _____

Consent for Services. I consent to services offered by Mental Health Center of Denver (MHCD). I understand that the primary objective of these services is to help me achieve a life of wellbeing. My consent is voluntary and will remain valid for as long as I am in an open status with MHCD. This consent applies to all providers at MHCD who may provide me with services and permits the sharing of information amongst MHCD staff, as permitted by law. I may withdraw my consent at any time, unless there is an involuntary treatment order from the court. Withdrawal of consent will not affect actions already taken, or in progress, by MHCD. MHCD also has the right to stop providing me with services.

Release of Information. I understand that MHCD will need information about my past and present circumstances in order to provide me with the appropriate services. I further understand that if any of my providers are not given access to the information necessary for my treatment, as determined by the provider in his/her professional opinion, MHCD may discontinue treatment. I understand that if I am currently on probation or parole, I may need to sign an authorization to release information so my clinician can speak to my probation or parole officer.

Confidentiality. I understand that information about me, including information in my medical record and information shared by me during therapy sessions, is confidential and cannot be disclosed without my permission. There are some exceptions to this general rule of confidentiality. Circumstances under which information can be shared legally without my permission include, but are not limited to: danger to myself or others; suspicion or evidence of abuse or neglect of a child, elder, or at-risk adult; or grave disability.

Photographs. I agree that MHCD may take my photograph for identification, security, or other administrative purposes, and understand that MHCD will treat such photographs as confidential. I have the right to say I do not want my photograph taken, and MHCD will honor that request. Once my photograph is taken, I cannot ask MHCD to remove it from their electronic system. Any other photographs or video of me require separate consent.

CBI Report. I understand MHCD may request a Colorado Bureau of Investigation (CBI) report if there are any safety concerns.

Outcomes Data. I understand MHCD collects data on the outcomes (results) of services provided as part of routine service delivery, and may use the data for program evaluation, obtaining funding, or making professional presentations. I give MHCD permission to collect and use my service outcome data. If MHCD uses the data, no identifying information will be disclosed. I can withdraw this permission at any time by notifying MHCD in writing, but the withdrawal will not affect data already collected or used by MHCD.

Valuables. I understand MHCD is not responsible for the loss or damage of any valuable items that I bring to MHCD. These may be things like money, jewelry, glasses, dentures, hearing aids, electronic devices, cell phones, documents, personal medical devices, or other valuable items.

Rights. I understand that while receiving services from MHCD, I have the right to:

- Care and treatment that is respectful, and recognizes my dignity, cultural values, and religious beliefs.
- Be involved in the planning and/or revision of my treatment plan.
- Receive information about the methods of therapy, the techniques used, the duration of therapy (if known), and the fee structure.
- Refuse services, after being informed of the potential risks, benefits, and alternatives of my refusal, unless a physician determines that refusal would be unsafe for me or others, or a court mandates the service.
- Know the names, professional status, and experience of the staff that provide me with services.
- File a complaint or grievance about MHCD without fear of retaliation, and be informed of the procedures for filing a complaint or grievance, including contact information.
- Be spoken to in a manner and language I can understand.
- Seek a second opinion from a provider outside of MHCD, but I will be responsible for the cost and arrangements.

For Parents/Caregivers Giving Consent on Behalf of a Minor. This paragraph applies if I am a parent/caregiver of the minor child named above and it relates to me personally. I understand that if I receive my own mental health treatment at MHCD, it may be necessary for the clinicians on my child's treatment team to communicate with the clinicians on my treatment team; review information in my MHCD electronic medical record; and enter documentation into my MHCD electronic medical record. I consent to use of my medical information as described in this paragraph.

AGREEMENT

By signing below, I acknowledge that I have read, understand, and agree to this Consent for Services, and that I have received a copy of this form. I also acknowledge that I have been provided a copy of Mental Health Center of Denver's Notice of Privacy Practices.

Signature of individual or authorized representative _____ Date _____

Name of authorized representative (please print) _____ Relationship _____
(Legal documentation of the representative's authority may be required.)