Crisis information

Mobile crisis 1-800-724-0461

Weekdays from 4:30 pm – 8:00 am, Weekends and Holidays 24 hours

CCMH (Chautauqua County Mental Health) mainline 716-661-8330

Walk-in appointments available (do not need to be a current active patient to go)

M, T, W, TH 8:00 am - 7:30 pm & Fridays 8:00 am - 4:30 pm

WCA ER (24 hours) 716-664-8120

Crisis text line (24 hours) Text HOME to 741741

Warm line (peer run 4-11p) Call 1-877-426-4373 or text 716-392-0252

PARENTAL CONSENT TO TREAT A MINOR

I GIVE CONSENT FOR MY:

Son _____

Daughter _____

Foster Child _____

Ward of County or State _____

To participate in evaluation and /or treatment at the Chautauqua County Department of Mental Hygiene.

- I also understand that I must attend some appointments with him/her at the clinic in order for my child to continue to receive treatment. These are treatment planning sessions, treatment review sessions and the discharge session.

- I am also required to attend my child's appointment if they are being referred to see our consulting psychiatrist.

Parent/Guardian _____Date _____

Intake Worker _____Date _____

To be completed only if client is under the age of 18

Client ID: _____

Chautauqua County
Department of
Mental Hygiene

NAME: _____ **DATE OF BIRTH:** _____ **TODAY'S DATE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____ **COUNTY:** _____

HOME PHONE: _____ **CELL PHONE:** _____ **EMAIL:** _____

PRIMARY LANGUAGE: ☐English ☐Spanish ☐Other: _____ **ARE YOU PREGNANT:** YES NO

SOCIAL SECURITY #: _____ **SEX:** ☐Male ☐Female ☐ Transgender _____

PARENT/GUARDIAN INFORMATION: (Under 18 only)

Relation: _____ Relation: _____

Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Social Security #: _____ Social Security #: _____

Date of Birth: _____ Date of Birth: _____

☐ Check if present at evaluation ☐ Check if present at evaluation

Who has custody: ☐ Parent(s) ☐Family Member Other Than Parent ☐Other Individual (non-family Member)

Custody Effective Date: _____ Name of Custodian _____

EMPLOYMENT STATUS: ☐ Employed Full-Time ☐ Employed Part-Time Occupation: _____

Are you a migrant farm worker? Yes ☐ or No ☐

If Unemployed: ☐ Looking for Work ☐Not Looking for Work ☐ Disabled ☐Student ☐Retired

RACE: ☐White/Caucasian ☐Asian ☐Native American ☐ Black/African American ☐Hispanic ☐Other _____

ETHNIC ORIGIN: ☐Not of Ethnic Origin ☐Puerto Rican ☐Cuban ☐Latino ☐Mexican ☐Other _____

PLACE OF BIRTH: _____

COUNTRY OF ORIGIN: ☐USA ☐ Canada ☐Other _____ **MAIDEN NAME AND/OR ALIAS:** _____

MARITAL STATUS: ☐Single/Never Married ☐Married ☐Separated ☐Divorced ☐Living as Married ☐Widowed

EDUCATION: ☐ Highest Grade Completed ____ ☐ GED ☐ High School Graduate ☐Some College No Degree

☐ Associate's Degree ☐Bachelor's Degree ☐ Master's Degree

TYPE OF RESIDENCE: ☐Private Residence ☐Institution - Name of Institution: _____

Homeless: ☐Living in a Homeless Shelter ☐Living on the Streets

LIVING ARRANGEMENTS: ☐Living Alone ☐Living with Spouse or Related Person ☐Living with Non-Related Persons

NUMBER OF PERSONS LIVING IN HOUSEHOLD: _____

ARE YOU A VETERAN: YES NO **ARE YOU ON MILITARY DISABILITY:** YES NO

Client ID: _____

WHO REFERRED YOU TO THIS EVALUTION? **WHAT DATE YOU WERE REFERRED:** _____

Self Family/Friend School Primary Doctor CPS/DHHS Other: _____

Probation/Parole: _____ Court: _____ Legal Charges: _____

WHAT BRINGS YOU IN TODAY? *Circle the main reason and underline others that apply*

Depression Irritability/Anger Thoughts of Suicide/Self-Harm Relationship Conflicts Anxiety

Panic Attacks Attention Issues Behavioral Problems Drug/Alcohol Abuse or Addiction

Legal Mandate Other: _____

NICOTINE ASSESSMENT:

☐ I currently smoke/vape/chew ☐ Other Adult or child in the home smokes ☐ I would like to quit/ reduce

☐ I would like to know about available resources ☐ I am currently trying to quit ☐ Do Not Use Nicotine

Amount I am currently smoking/vaping/chewing _____

Staff Recommendation/Comments/Referrals:

_____

_____

EMERGENCY CONTACT INFORMATION: Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

For your convenience our office uses and automated appointment reminder system that can call or text you with information about your upcoming appointment.

☐ I consent to receiving this information. ☐ I prefer to receive a text message. **OR** ☐ I prefer a phone call.

Number to send reminder notifications to: _____

☐ Send me a Patient Portal referral. *(This helps you to link with our program electronically. You can see your appointments, request medications, send a message, or request an appointment.)*

☐ I'd like a demo ☐ I'd like help creating my account

☐ Send me a myStrength referral. *(This is a self-help website that is full of activities that will help you to work toward your mental wellness goals from a computer or smart phone/tablet.)*

☐ I'd like a demo ☐ I'd like help creating my account

☐ I'd like to learn more about self-help meetings available in the area.

☐ I'd like a referral to a primary care doctor and/or dentist.

☐ I'm in the process of getting health insurance and/or I'd like assistance with getting insurance.

PLEASE SIGN:

Client Signature: _____ Date _____

Staff Signature: _____ Date _____

Chautauqua County Department of Mental Hygiene
Financial Data Sheet

Last Name:_____ First Name:_____ MI:___

Address:_____ City:_____ State:_____ Zip Code:_____

Date of Birth:_____ Sex: M or F Circle Race: W B H A N O

Person Responsible for Primary Insurance

Last Name:	First Name:	MI:	Birth Date:
Address:	City:	State:	Zip Code:
Telephone:		Sex: M or F	
	Employer:		
Employer Address:	City:	State:	Zip Code:
Patient Relationship to Insured: (circle) Self Spouse Child	Insurance Company Name and Address:		
Policy Number:	Group Number:	Co-Payment:	Deductible:

Person Responsible for Secondary Insurance

Last Name:	First Name:	MI:	Birth Date:
Address:	City:	State:	Zip Code:
Telephone:		Sex: M or F	
	Employer:		
Employer Address:	City:	State:	Zip Code:
Patient Relationship to Insured: (circle) Self Spouse Child	Insurance Company Name and Address:		
Policy Number:	Group Number:	Co-Payment:	Deductible:

Medicaid CIN:	Extra Information:

I hereby authorize CCDMH to release all medical information necessary to secure payment of benefits from the third party payers specified above or any other insurance that may be applicable at time of service, and I authorize the use of this signature on all related submissions. I agree to assign insurance benefits to be paid directly to Chautauqua County Mental Hygiene. I agree to forward any insurance payments I receive directly to Chautauqua County Mental Hygiene to pay for services rendered. I understand that if my account is more than 120 days overdue, it will be sent to a collection agency. If I fail to inform the clinic of all insurance payers, I understand that I will be responsible for the full cost of the services provided to me.

Signature: _____ Date: _____

Sliding Fee Discount Application

It is the policy of the Chautauqua County Department of Mental Hygiene, to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk to determine if you or members of your family are eligible for a discount. The discount will apply to all services received at this clinic, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

Please List Self, Spouse and all Dependents below:	Date of Birth	**Continue**	Date of Birth
Self:		Dependent Name:	
Spouse Name:		Dependent Name:	
Dependent Name:		Dependent Name:	
Dependent Name:		Dependent Name:	

Annual Household Income Source	**Self**	**Spouse**	**Other**	**Total**
Gross Wages, salaries, tips, etc.				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplement Security Income, public assistance, Veterans' payments, survivor benefits, pension, or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources				
Total Income				

Note: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I hereby acknowledge that I have read the above and I certify that the statements are true. I understand my ability to pay for services has been determined to be $_____ per visit.

Signature: _____ Date: _____

I agree that I will be held personally responsible for all charges related to instant lab screens. ***Initial***_____

I am financially responsible for other lab screens if I choose not to have them billed to my insurance. ***Initial***_____

Medicare Only Client:

- o I understand that due to my clinical needs and/or staff availability, I may be seeing a clinician who is not Medicare payable. I agree to pay $10 for an initial open access assessment. ***Initial*** _____
- o I understand that due to my clinical special/forensic needs, I may be seeing a clinician who is not Medicare payable. I agree to pay an income based sliding fee for those services. ***Initial***_____

For Office Use Only

Approved Discount Amount: $ _____ Approved by: _____ Date: _____

Initial on each line below that you have verified proof:

_____Proof of Identification _____Proof of Income (Tax return or 3 paystubs) _____Proof of Insurance (Insurance Card)

CONSENT

(To be completed by the patient or his or her personal representative)

I hereby consent to permit the Practice to use and disclose my personally identifiable information for purposes related to my treatment, for purposes related to obtaining payment for my treatment, and for other purposes where Federal law does not require my further Authorization.

Name of Patient

Signature of Patient

OR, if authorization given by Personal Representative:

Signature of Personal Representative
(e.g., Attorney-in-fact, Guardian)

Description of Authority to act as
Personal Representative of the Patient

Date signed ____ / ____ / _____

This document shall be retained six years from the date of its creation or six years from the date it is last in effect, whichever is later (§164.530(j)(2)).

Effective Date: September 23, 2013	Refer to : 45 CFR 164.506(b)
Authorized by:	Version #2013-1

CHAUTAUQUA COUNTY MENTAL HEALTH CLINIC

CLIENT RIGHTS AND RESPONSIBILITIES

CLIENT RIGHTS:

1. Clients have a right to competent, considerate and respectful care. Client's privacy and individuality are to be respected in all client/staff interactions.
2. If a client has a complaint about how he/she is treated by a staff member, a client may contact the clinic director. The client has the right to file a complaint with the clinic director and upon request will be supplied with the information about how such a complaint may be filed.
3. A client has the right to voluntarily decide to terminate treatment in the clinic.
4. During the pre-admission process, client rights and responsibilities will be discussed with the client, signed by the client and the therapist and placed in the case record. A copy will be made available to the client upon request.
5. Active participation in the implementation of a treatment plan.
6. Clients have the right to an individual plan of treatment services and to participate to the fullest extent consistent with the recipient's capacity in the establishment and revision of that plan.
7. Clients have the right to a full explanation of the services provided in accordance with their treatment plan.
8. Participation in treatment in a clinic program is voluntary and recipients are presumed to have the capacity to consent to such treatment. The right to participate voluntarily in and to consent to treatment shall be limited only pursuant to a court order or in accordance with applicable provisions of law.
9. While a client's full participation in treatment is a central goal, a client's objection to his/her treatment plan, or disagreement with any portion thereof, shall not, in and itself, result in his/her termination from the program unless such objection renders continued participation in the program clinically inappropriate or would endanger the safety of the client or others.
10. The confidentiality of client's clinical records shall be maintained in accordance with applicable state and federal laws and regulations, which may include, but are not limited to Section 33.13 of the Mental Hygiene Law, Article 27-F of the Public Health Law, the Health Insurance Portability and Accountability Act (HIPAA), and 42 CFR Part 2.
11. Clients shall be assured access to their clinical records, including their mental illness diagnosis, consistent with Section 33.16 of the Mental Hygiene Law and applicable federal requirements.
12. Clients have the right to receive clinically appropriate care and treatment that is suited to their needs and skillfully, safely and humanely administered with full respect for their dignity and personal integrity.
13. Clients have the right to receive services in such a manner as to assure nondiscrimination.
14. Clients have the right to be treated in a way that acknowledges and respects their cultural environment.
15. Clients have the right to a reasonable degree of privacy consistent with the effective delivery of services.
16. Clients have the right to freedom from abuse and mistreatment by employees.
17. Clients have the right to be informed of the provider's recipient grievance policies and procedures, and to initiate any question, complaint or objection accordingly.

NOTICE TO CLIENT OF CONFIDENTIALITY:

The clinic will not disclose any information about the client's attendance and treatment unless:

1. The client consents in writing, or
2. The disclosure is court ordered, or
3. The disclosure is made to qualified professionals for emergency reasons.

Clients must be aware that there are circumstances in which confidentiality cannot be assured, notably in cases of suspected child abuse, or in situations where there is evidence of imminent danger of suicide or homicide.

CLINIC POLICY REGARDING ATTENDANCE AND CANCELLED APPOINTMENTS:

It is your responsibility to maintain contact with the clinic and if you do not, the clinic reserved the right to discontinue or limit services under the following conditions:

1. You are required to provide the clinic with 24-hour prior notice to cancel an appointment and anything less is considered to an appointment failure.
2. Three consecutive cancellations or failures will automatically result in case closure.
3. If you have not been seen by clinic staff at least once every 60 days, your case will be closed, with exceptions made for medication clinic only clients.
4. Contact with the clinic is required. Failure to do so may result in closure of your case prior to 60 days.
5. If you choose to discontinue treatment at the clinic, it is your responsibility to notify clinic staff.

FINANCIAL OBLIGATION:

1. A Financial Data Sheet must be completed by all applicants on the first visit. A fee for services is established based on client's income information. The clinic has the right to request proof of income. Each client has the right to an explanation about the billing process.
2. **Payment for services must be made at each appointment.**
3. If a client has not made a payment in three consecutive appointments, a meeting will be arranged with the office manager to discuss financial arrangements prior to scheduling another appointment.
4. The clinic accepts Medicaid for full payment of services.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	Record #:	DOB:

Part A
Brief Medical Screening

Doctor's Name:	Address:	Phone Number:	Date of Last Exam:
Dentist's Name:	Address:	Phone Number:	Date of Last Exam:

Has a Doctor EVER told you that you had any of the following conditions?

Condition	Check One		Currently Under a Doctor's Care	Comment
	Now	Past		
Alzheimer's Disease or Dementia	☐	☐	☐ No ☐ Yes	
Blood Sugar-High	☐	☐	☐ No ☐ Yes	
Blood Pressure (High)	☐	☐	☐ No ☐ Yes	
Cancer	☐	☐	☐ No ☐ Yes	
Deafness or other hearing impairment	☐	☐	☐ No ☐ Yes	
Diabetes	☐	☐	☐ No ☐ Yes	
Endocrine Condition (High or Low thyroid, Pituitary or Adrenal Disease)	☐	☐	☐ No ☐ Yes	
Epilepsy/Seizures	☐	☐	☐ No ☐ Yes	
Heart Attack	☐	☐	☐ No ☐ Yes	
Hyperlipidemia (High blood fat/Cholesterol and/or Trigycerides)	☐	☐	☐ No ☐ Yes	
Joint and connective tissue disease (Lupus, Rheumatoid arthritis, Osteoporosis, Osteoarthritis	☐	☐	☐ No ☐ Yes	
Kidney Disease	☐	☐	☐ No ☐ Yes	
Liver Disease ((Cirrhosis), Hepatitis A/B/C))	☐	☐	☐ No ☐ Yes	
Mobility Impairment	☐	☐	☐ No ☐ Yes	
Other Cardiac Condition	☐	☐	☐ No ☐ Yes	
Progressive neurological condition (Multiple Sclerosis (MS), Cerebral palsy, Amyotrophic Lateral Sclerosis (ALS))	☐	☐	☐ No ☐ Yes	
Pulmonary (Emphysema (Chronic Pulmonary Disease (COPD), Asthma)	☐	☐	☐ No ☐ Yes	
Sexually Transmitted or other Communicable Disease (for example, Herpes, Human Immunodeficiency Virus (HIV), History of active tuberculosis)	☐	☐	☐ No ☐ Yes	
Sight Impairment	☐	☐	☐ No ☐ Yes	
Speech Impairment	☐	☐	☐ No ☐ Yes	
Stroke	☐	☐	☐ No ☐ Yes	
Traumatic Brain Injury	☐	☐	☐ No ☐ Yes	
Weight (Obesity, Unexplained Gain or Loss)	☐	☐	☐ No ☐ Yes	
Other physical related health conditions	☐	☐	☐ No ☐ Yes	

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	Record #:	DOB:

CURRENT Medication Information ☐ None
(Include all current medication-Psychiatric/Non-Psychiatric, Prescription/Over-the-counter drugs/Herbal)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional:

Medication HISTORY Information ☐ None
(As best as possible, list all additional medications taken for psychiatric or substance abuse issues in the past)

Medication	Reason for Taking	Dosage/Frequency and When taken (Dates/Length of time)	Side-effects	Helpful?	Prescriber
				☐ No ☐ Yes	
				☐ No ☐ Yes	
				☐ No ☐ Yes	

Additional - Are there any medications you would like to avoid taking in the future?:

Allergies/Drug Sensitivities ☐ None

☐ Food (specify):

☐ Medicine (specify):

☐ Latex / ☐ Other (specify):

Medical hospitalizations/significant operative and invasive procedures?
☐ No ☐ Yes If yes, complete information below:

Hospital	Date	Reason

Comments:

Organization Name:	Program Name:	Date:
Individual's Name (First MI Last):	Record #:	DOB:

Nutrition/Hydration Screening Check if you have experienced:

1. ☐ **Any weight loss or gain of 10 pounds or more in the past three months**
2. ☐ **Change in appetite**
3. ☐ **Are you experiencing any other problems eating or drinking?**

The Joint Commission

Pain Screening

Do you have any ongoing pain problems? ☐ No ☐ Yes If yes, Medical Staff completes pain section below.

For Women Only

Currently pregnant?

☐ No ☐ Yes - If yes, expected delivery date:

Are you currently breastfeeding? ☐ No ☐ Yes

Receiving pre-natal healthcare?

☐ No ☐ Yes – If yes, indicate provider:

Any significant pregnancy history?

☐ No ☐ Yes – If yes, explain:

Menstruation

Last menstrual Period Date:

Menstrual Pain: ☐ No ☐ Yes

Menstrual Irregularities: ☐ No ☐ Yes ☐ Other:

Pre-menstrual symptoms: ☐ No ☐ Yes

Polycystic Ovary Syndrome? ☐ No ☐ Yes

If yes, Indicate provider:

For Children Only

Immunizations: Has the child or adolescent been immunized for the following diseases? Please check all that apply.

☐ Chicken Pox ☐ Diphtheria ☐ German Measles (rubella) ☐ Hepatitis B ☐ Measles ☐ Mumps

☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other:

All immunizations up to date? ☐ Yes ☐ No – Comments:
Prenatal exposure to Alcohol or other Drugs? ☐ Yes ☐ No – Comments:
Any other significant information that may affect care or place the child or adolescent at risk (for example, accidents or injuries):

Completed By - Print Name:	Signature:	Date:

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | Office of Alcoholism and Substance Abuse Services

OMH Health Screen
NYSCRI v3.0.1, 03-2016

Organization Name:	Program Name:	Date:
Individual's Name: (First, MI, Last)	Record #:	Date of Birth:

Recommended health services or referrals

☐ Nutrition/Hydration	
☐ Pain	
☐ Other Specialty Care / Service	
☐ Primary Care Physician (General Referral)	
☐ Primary Care Physician for Physical Exam and Date, if known	

Clinical Summary of Findings

Health Information Reviewed by: Staff Name/Title/Credentials:	Signature:	Date:

CHAUTAUQUA COUNTY DEPARTMENT OF MENTAL HYGIENE	DATE : JUNE 1994 REVISED : SEPTEMBER 2014	PG 1 OF 1
	SUBJECT : CLIENT COMPLAINT PROCEDURE	
OUTPATIENT CLINICS POLICY AND PROCEDURE MANUAL	APPROVED BY : PATRICIA A. BRINKMAN, DIRECTOR	

Purpose:

Clients have the right and the ability to voice concerns regarding treatment and seek remedies regarding those concerns.

Definition:

A client complaint is deemed to be any client issue that cannot be resolved by direct contact between the client and counselor or staff. These can include, but are not limited to, complains regarding treatments, access to care, billing, involvement in the treatment planning process discharge arrangements, etc.

Procedure:

1. Clients are urged to contact their primary counselor as a first step to complaint resolution. The therapist will respond in session and identify for the client how to resolve the complaint or what will be the next step at the time of the complaint.

2. If the meeting with the counselor does not result in satisfactory action, the client should request a meeting with the Clinic Director and primary counselor to review the complaint. The Clinic Director or designee will respond to the complaint within a 72 hour period. At this point, the Clinic Director will initiate the Client Complaint Documentation Form. The client will provide the Clinic Director with his/her details regarding the nature of the complaint. The Clinic Director will complete the Client Complaint Documentation Form within a 72 hour period and advise via phone or by scheduling a meeting the results of the complaint to all parties involved.

3. If unresolved at the Clinical Director level, the client will be provided an opportunity to meet with the Director of Mental Hygiene. If the client contacts the Director, every effort will be made by the Director or his/her designee to meet within seven (7) business days of the initial contact. The Director can be reached at: 7 N. ERIE STREET, MAYVILLE, NY 14757; Phone: (716)753-4104

4. If unresolved at the Director level, the following Regional and State agencies can be contacted to further review the complaint:

NYS OMH Field Office
737 Delaware Ave.
Buffalo, NY 14209
(716) 885-4219

Alliance for the Mentally Ill of NYS
302 Parkhurst Blvd.
Buffalo, NY 14223
(716) 862-8229

Protection and Advocacy for Mentally Ill Individuals Program
Neighborhood Legal Services, Inc.
295 Main St., Room 495
Buffalo, NY 14204
(716) 847-0650

NYS Commission on Quality of Care
99 Washington Ave., Suite 1002
Albany, NY 12210
1-800-624-4143

Mental Hygiene Legal Services
50 East Ave.
Rochester, NY 14620
(585) 530-3050

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

Consent Form

Chautauqua County Department Of Mental Hygiene

Provider/Facility Name

About PSYCKES

The New York State (NYS) Office of Mental Health maintains the Psychiatric Services and Clinical Enhancement System (PSYCKES). This online database stores some of your medical history and other information about your health. It can help your health providers deliver the right care when you need it.

The information in PSYCKES comes from your medical records, the NYS Medicaid database and other sources. Go to **www.psyckes.org**, and click on **About PSYCKES**, to learn more about the program and where your data comes from.

This data includes:

- Your name, date of birth, address and other information that identifies you;
- Your health services paid for by Medicaid;
- Your health care history, such as illnesses or injuries treated, test results and medicines;
- Other information you or your health providers enter into the system, such as a health Safety Plan.

What You Need to Do

Your information is confidential, meaning others need permission to see it. Complete this form now or at any time if you want to give or deny your providers access to your records. What you choose will not affect your right to medical care or health insurance coverage.

Please read the back of this page carefully before checking one of the boxes below. Choose:

- "I GIVE CONSENT" if you want this provider, and their staff involved in your care, to see your PSYCKES information.
- "I DON'T GIVE CONSENT" if you don't want them to see it.

If you don't give consent, there are some times when this provider may be able to see your health information in PSYCKES – or get it from another provider – when state and federal laws and regulations allow it.[1] For example, if Medicaid is concerned about the quality of your health care, your provider may get access to PSYCKES to help them determine if you are getting the right care at the right time.

Your Choice. *Please check 1 box only.*

◯ **I GIVE CONSENT** for the provider, and their staff involved in my care, to access my health information in connection with my health care services.

◯ **I DON'T GIVE CONSENT** for this provider to access my health information, but I understand they may be able to see it when state and federal laws and regulations allow it.

Print Name of Patient

Patient's Date of Birth

Patient's Medicaid ID Number

Signature of Patient or Patient's Legal Representative

Date

Print Name of Legal Representative (if applicable)

Relationship of Legal Representative Patient (if applicable)

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

NEW YORK STATE OF OPPORTUNITY. | Office of Mental Health | PSYCKES

Information and Consent

1. **How providers can use your health information.** They can use it only to:
   - Provide medical treatment, care coordination, and related services.
   - Evaluate and improve the quality of medical care.
   - Notify your treatment providers in an emergency (e.g., you go to an emergency room).

2. **What information they can access.** If you give consent, Chautauqua County Department Of Mental Hygiene can see ALL your health information in PSYCKES. This can include information from your health records, such as illnesses or injuries (for example, diabetes or a broken bone), test results (X-rays, blood tests, or screenings), assessment results, and medications. It may include care plans, safety plans, and psychiatric advanced directives you and your treatment provider develop. This information also may relate to sensitive health conditions, including but not limited to:
   - Mental health conditions
   - Alcohol or drug use
   - Birth control and abortion (family planning)
   - Genetic (inherited) diseases or tests
   - HIV/AIDS
   - Sexually transmitted diseases

3. **Where the information comes from.** Any of your health services paid for by Medicaid will be part of your record. So are services you received from a state-operated psychiatric center. Some, but not all information from your medical records is stored in PSYCKES, as is data you and your doctor enter. Your online record includes your health information from other NYS databases, and new databases may be added. For the current list of data sources and more information about PSYCKES, go to: www.psyckes.org and see "About PSYCKES", or ask your provider to print the list for you.

4. **Who can access your information, with your consent.** Chautauqua County Department Of Mental Hygiene 's doctors and other staff involved in your care, as well as health care providers who are covering or on call for Chautauqua County Department Of Mental Hygiene. Staff members who perform the duties listed in #1 above also can access your information.

5. **Improper access or use of your information.** There are penalties for improper access to or use of your PSYCKES health information. If you ever suspect that someone has seen or accessed your information – and they shouldn't have – call:
   - _____ at _____, or
   - the NYS Office of Mental Health Customer Relations at **800-597-8481.**

6. **Sharing of your information.** Chautauqua County Department Of Mental Hygiene may share your health information with others only when state or federal law and regulations allow it. This is true for health information in electronic or paper form. Some state and federal laws also provide special protections and additional requirements for disclosing sensitive health information, such as HIV/AIDS, and drug and alcohol treatment.[1]

7. **Effective period.** This Consent Form is in effect for 3 years after the last date you received services from Chautauqua County Department Of Mental Hygiene, or until the day you withdraw your consent, whichever comes first.

8. **Withdrawing your consent.** You can withdraw your consent at any time by signing and submitting a Withdrawal of Consent Form to _____. You also can change your consent choices by signing a new Consent Form at any time. You can get these forms at **www.psyckes.org** or from your provider by calling _____ at _____. Please note, providers who get your health information through Chautauqua County Department Of Mental Hygiene while this Consent Form is in effect may copy or include your information in their medical records. If you withdraw your consent, they don't have to return the information or remove it from their records.

9. **Copy of form.** You can receive a copy of this Consent Form after you sign it.

[1] Laws and regulations include NY Mental Hygiene Law Section 33.13, NY Public Health Law Article 27-F, and federal confidentiality rules, including 42 CFR Part 2 and 45 CFR Parts 160 and 164 (also referred to as "HIPAA").

Chautauqua County Department of Mental Hygiene
Certified Community Behavioral Health Clinic

PARTICIPANT CONSENT FORM

Client Name:	
Client DOB:	
EMR #	
Date of Consent:	

Chautauqua County Department of Mental Hygiene was awarded an opportunity to participate in a grant project with SAMHSA. This project has allowed CCDMH to become a Certified Community Behavioral Health Clinic. The goal of this CCBHC is to strengthen community-based behavioral health and substance use disorder treatment while integrating behavioral health care alongside physical health care. In order to reach our goals and better meet the needs of our community we need to collect data to demonstrate our participation with the SAMHSA grant project and our commitment to our community members.

As your Certified Community Behavioral Health Clinic and provider, we believe it is important for you understand all aspects of your treatment and recovery process with us. Additionally, we understand the importance of adequate participant protection. This form is meant to inform you of this grant project, to help you understand the data collection involved with this project, and to inform you of any potential risks.

The collection of data is important for us in measuring how we are servicing our community's and clients' needs. It is important that you understand that we will report to SAMHSA on our data outcomes but will not disclose any of our client's personal identifying information. Therefore, the risk of participating in this project is expected to be minimal because we have taken steps to protect your privacy, including but not limited to: Staff are trained to keep information private, to keep any files lacked away or encrypted, and the consequences of breaching a participant's confidentiality. The privacy of the information we collect about any of our participants will be very carefully protected.

Only researchers involved with this project through CCDMH will have access to any potentially identifying information.

It is also important that we ensure you know that there are three areas that we expected to report on that we cannot ensure participant confidentiality due to safety of others. These three areas are:

1. Communicable Diseases. SAMHSA policy requires grantees to report communicable diseases voluntarily per state laws when participating in projects that test participants for diseases.
2. Suspected Cases of Child Abuse or Neglect. SAMHSA policy requires grantee to report suspected cases of child abuse or neglect to the proper local authorities while voluntarily

following state laws. It is important for parents and children to understand this exception to confidentiality.

3. Harm to Self and Others. If there is a danger that a participant will harm himself or herself, or others, the potential danger will be reported voluntarily through the appropriate channels to ensure safety.

Also, due to this research, or collection of data, is sponsored by Health and Human Services (HHS), staff from HHS may review records that identify participants during an audit of this project.

By signing this form you consent to the following:

1. To participate in this project/service intervention.
2. You understand and agree to participate in the data collection component of this project.
3. You agree to allow us, through releasing or requesting, confidential information to/from members of your health care team.

Client Signature:

Caregiver Name and Signature (when applicable):

Date:

Witness Name and Title:

Witness Signature:

Date:

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
SouthernTier Pediatrics / 1684 Foote Ave, Jamestown, NY 14701 /(716) 661-9730

8. Name and address of person(s) or category of person to whom this information will be sent:
Chautauqua County Department of Mental Hygiene / 200 East 3rd Street Jamestown, NY 14701/ 716-661-8330

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **Status, compliance, recommendations &care coord.**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ (Initials) I authorize **SouthernTier Pediatrics / 1684 Foote Ave, Jamestown, NY** (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:
Chautauqua County Department of Mental Hygiene / 200 East 3rd Street Jamestown, NY 14701/
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Parent/Caregiver/Guardian**	**90 days after discharge date**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Patient Address		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

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2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Chautauqua County Department of Mental Hygiene / 200 East 3rd Street Jamestown, NY 14701/ 716-661-8330

8. Name and address of person(s) or category of person to whom this information will be sent:
SouthernTier Pediatrics / 1684 Foote Ave, Jamestown, NY 14701 /(716) 661-9730

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- ☐ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☑ Other: **Status, compliance, recommendations &care coord.**

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here _____ (Initials) I authorize **Chautauqua County Department of Mental Hygiene / 200 East 3rd** (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:
SouthernTier Pediatrics / 1684 Foote Ave, Jamestown, NY 14701 /(716) 661-9730
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☐ At request of individual ☑ Other: **Parent/Caregiver/Guardian**	**90 days after discharge date**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**