Instructions for completing consent forms:

- Use **BLACK** ink <u>only</u> when completing consent forms
- If you make an error, no white out or blacking out incorrect information, please draw a single line through incorrect information and initial
- LAR- legal authorized representative; please place name of legal guardian of child on ALL blanks labeled "LAR"
- ECET ID or Social Security number, please leave these blanks empty, that will be assigned by GCC staff
- Please ***<u>INITIAL</u>*** any blanks requesting your understanding, check marks are not allowed
- Please sign and date all forms
- Indicate Date of Birth as MM/DD/YEAR= (12/03/2004)
- Written Consent forms:
  1 is for PCP-Primary Care Physician, 1 is for the school, 1 is for any other provider who may have records, CPS, Juvenile Detention, ect.
  Fully complete the top section with provider name/staff/address/phone/fax
- Permission to Represent form:
  This is to completed ONLY if there is someone else who you will be giving permission to bring your child for services and allow consents for such; initial all blanks in which you are giving permission for decisions to be made for your child on your behalf
- If you have questions or items are unclear please leave blank (ask for clarification on those items when meeting with screening staff)

<u>Your signatures for ALL documents will be completed when meeting face to face with screening staff</u>.

<u>Please print single sided</u>

Thank you!

Contact Information

ECET ID:

Client Name:

Legal Authorized Representative (LAR):

Address:

Home Phone:

Work Phone:

Mobile Phone:

Emergency Contact:

Relationship to Client:

Phone Number:

LAR Signature:

GULF COAST CENTER
CONSENT FOR EVALUATION AND SERVICES

Full Legal Name: _____

Client ID: _____ Date of Birth: ____/____/_____

I, _____

(Printed name of person receiving services or his/her legally authorized representative)

do hereby authorize my consent for evaluation, treatment, and services by Gulf Coast Center. By initialing the blanks below, I acknowledge that I have read (or that someone has read to me) the statements and that I understand the contents of the statements:

_____ I understand that the determination for treatment, if any, shall be made by Gulf Coast Center staff. I further understand that any such recommendations shall be explained fully and that I have the option to accept or reject the recommendations.

_____ I certify that I have received a copy of, and have had explained to me in a language that I can understand, my rights as a person receiving services from Gulf Coast Center. Some of these rights are printed on the reverse side of this form, and other rights are explained in the Rights Handbook, which I have also received. I understand that if I have any questions regarding my rights as a person receiving services, I may ask Gulf Coast Center staff for clarification.

_____ I understand that communication with Gulf Coast Center professionals during the course of treatment at any Health and Human Services (HHSC) / Department of Aging and Disability (DADS) or HHSC / Department of State Health Services (DSHS) facility may be disclosed to the court in the course of future court proceedings.

_____ I understand that information about me, to include clinical records, may be disclosed to other elements of the HHSC / DADS or HHSC / DSHS or agencies with whom Gulf Coast Center designates as contract providers for purposes of treatment and/or continuing care. I further understand there may be other, limited occasions according to State law, Federal law, and/or Center procedures, in which information about me may be disclosed to individuals within the Center or to outside agencies for the purposes of quality management, utilization management, regulatory compliance, treatment, payment and Center/health care operations. I understand that there may be occasions where information about me may be used anonymously for data collection or research purposes.

_____ I understand that my treatment information will be shared with the Gulf Coast Center's contracted Primary Care Provider(s) if I receive on-site *physical health care services* through the Center's Integrated Health Care program.

_____ I understand that I may designate whether or not I would like Gulf Coast Center to share treatment information with my *external* Primary Care Provider/other Healthcare Providers: ☐ I DO want my information shared (appropriate authorization(s) must be signed); ☐ I DO NOT want my information shared.

_____ I understand that in order to continue services at Gulf Coast Center, I must maintain contact and remain active in services. Should services be terminated for any reason, I understand that I have the right to appeal. I certify that I have received a copy of Gulf Coast Center's appeal information.

_____ _____
Signature of Person Receiving Services Date

_____ _____
Signature of Legally Authorized Representative of Person Receiving Services Date

_____
Relationship of Legally Authorized Representative to Person Receiving Services

_____ _____
Signature of Witness Date

_____ _____
Signature of Witness* Date

*Two witness signatures are required when an individual does not have a LAR and signs his or her name with an "X" or an illegible mark.

GULF COAST CENTER

RIGHTS PROTECTION INFORMATION ACKNOWLEDGMENT

Your signature on the reverse side of this form acknowledges that you have received a written copy of your rights and that these rights have been explained to you in language that you can understand.

Eligibility - You may be eligible for services if you are experiencing mental illness, chemical dependency or an intellectual or developmental disability or and you meet admission criteria. If I am admitted for services, I understand that in order to continue services at Gulf Coast Center, I must maintain contact and remain active in services. Should services be terminated for any reason, I understand that I have the right to appeal. I certify that I have received a copy of Gulf Coast Center's appeal information.

Confidentiality - Records about your services are private. Others cannot see your records unless you or your legally authorized representative give written authorization for the release of your information, or if the release of your information is allowed by State law, Federal law, and/or Center procedures. Your information may be disclosed without specific written authorization for the purpose of quality management, utilization management, regulatory compliance, treatment, payment, and Center health care operations. You have the right to see or have a copy of your records. However, a professional must review your information first to determine if access to the information would not be in your best interest (as required by the Texas Administrative Code, Protected Health Information, Chapter 414, Subchapter A and Chapter 4 Subchapter A).

Fees - Gulf Coast Center charges for many of its services. The amount that you will be asked to pay must be based on a sliding fee scale, depending upon you and/or your family's income and number of family members. You have a right to see the sliding fee scale and financial assessment paperwork. If you have third party insurance, you will be responsible for designated deductibles, coinsurance, and/or co-pays.

Communication - You have the right to receive this and all other notices in a language that you understand best, or, if needed, a translation of such orally, in sign language, or in Braille, as appropriate.

Complaints - You may file a complaint if you believe any of your rights have been violated or if or you have other concerns regarding your services.

You may contact any of the individuals/agencies listed below. We suggest, however, that you talk first with a staff member who provides services to you. If necessary, talk to his or her supervisor. If you are uncomfortable discussing the problem with the staff member or his or her supervisor, or if the problem is still not resolved to your satisfaction, you may call or write Gulf Coast Center's Rights Protection Officer (see below). Upon receipt of the complaint, the Rights Protection Officer will initiate an investigation within five (5) working days. The investigation shall be completed as soon as possible, but no more than fourteen (14) working days following its initiation unless significant extenuating circumstances exist (e.g. absence of a key witness, addition of new information requiring follow-up, etc). If the problem is still not resolved to your satisfaction, you may call or write any of the other contacts listed below.

Gulf Coast Center
Rights Protection Officer
4444 West Main
League City, Texas 77573
1-888-839-3229
cindyk@gulfcoastcenter.org

HHSC/ DSHS
Crisis Services & Client Rights Unit
8317 Cross Park Drive, MC: 2018
Austin, Texas 78754
1-800-252-8154

HHSC/DADS
Consumer Rights and Services
P.O. Box 149030
Austin, Texas 78714-9030
1-800-458-9858

HHSC/DSHS
Substance Use Recovery
Patient Quality Care

Disability Rights Texas
7800 Shoal Creek Blvd., Suite 171-E
Austin, Texas 78757
1-800-832-9623
1-800-252-9108 (voice and TDD)

FOR REPORTING ABUSE, NEGLECT, OR EXPLOITATION IMMEDIATELY CONTACT:
Texas Department of Family and Protective Services 1-800-647-7418.

GULF COAST CENTER
MENTAL HEALTH • SUBSTANCE USE RECOVERY
INTELLECTUAL & DEVELOPMENTAL DISABILITIES

Client Name: _____ Client ID: _____

Child & Adolescent Services Consumer Engagement Policy

Please initial next to each of the following statements to indicate each item has been read and is understood:

_____ It is my responsibility to provide updated contact information to clinic staff regularly/ as needed to ensure no interruption in service provision for my child.

_____ It is my responsibility to ensure that ongoing appointments are scheduled according to my child's treatment plan to ensure services are not interrupted due to non-engagement.

_____ It is my responsibility if I need to cancel or reschedule an appointment, to contact a Gulf Coast Center staff member within 24 hours of my appointment. I understand that my child could be discharged from services due to non-participation (engagement).

_____ I understand after two consecutive missed (cancellation or no-show) appointments, a letter will be mailed to me with a final face to face appointment date/time. If the appointment is not kept as indicated in the letter, all services will be closed including medication management services. Emergency-related absences will be considered on a case by case basis and subject to verification.

_____ I understand after discharge from services occurs, families requesting re-entry to services will be requested to meet with clinic staff to complete new assessment and treatment plan; if it has been 90 days since last seen, families will need to go through initial screening process again to review needs and interest in services.

I understand the above terms, and I am aware of my responsibilities to contact the Gulf Coast Center Child & Adolescent Services to coordinate services per my child's treatment plan. I agree to adhere to service requirements and will be provided with a copy for my records.

Client's Name _____

LAR Signature _____ **Date**_____

Staff/Witness Signature_____ **Date**_____

Handbook of Consumer Rights

Consumer Services and Rights Protection
2007

Table of Contents

Under law, the state facility or community mental health center is responsible for making sure that you have been informed of your rights. The DSHS system is required to respect and provide for your rights.

To help you determine which rights in this handbook apply to you, you should be aware of your status with respect to the following conditions:

- the type of treatment program you are in (outpatient, inpatient, or other residential);
- your legal status (competent adult, adult or minor with a guardian, emancipated minor, or minor with a conservator);
- your admission status (voluntary, emergency detention, Order of Protective Custody, Court Order for Temporary or Extended Services, or Forensic Commitment).

If you are not sure of your status, ask your treatment provider or ask for assistance from your Rights Protection Officer.

- Joint Commission on Accreditation
  of Healthcare Organizations [1]
  One Renaissance Blvd.
  Oakbrook Terrace, IL 60181
  1-800-994-6610

You have the right to be told about Advocacy, Inc. when you first enter an inpatient unit and also when you leave. Advocacy, Inc., is a federally-funded agency which is independent of DSHS and whose purpose is to protect and speak up for your rights.

If you believe you have been abused or neglected, you can complain to:

Texas Department of Family and Protective Services
P.O. Box 149030
Austin, TX 78714-9030
Mail Code E-561
1-800-647-7418

If you believe your attorney did not prepare your case properly or that your attorney failed to represent your point of view to the judge when you were involuntarily committed, you may report the attorney's behavior to the State Bar of Texas by writing or calling:

State Bar of Texas
Chief Disciplinary Counsel
La Costa Center, Suite 300
6300 La Calma Dr.
Austin, TX 78752
1-800-932-1900

You have the right to be offered the opportunity to complete a satisfaction survey at discharge from an inpatient program, telling us what you did like or did not like. You may request an early survey at any time during your stay by asking your social worker or by contacting the Office of Consumer Services. This right extends to your family.

[1] Applies to inpatient programs and accredited outpatient programs.

8. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the program's reimbursement, and any limitations on length of services. You should be given a detailed bill of services upon request, the name of an individual to contact for any billing questions, and information about billing arrangements and available options if insurance benefits are exhausted or denied. You may not be denied services due to an inability to pay for them.

9. You have the right to fair compensation for any work performed in accordance with the Fair Labor Standards Act.

10. When you are admitted to an inpatient or outpatient program, you have the right to be informed of all rules and regulations related to those programs.

Confidentiality

11. You have the right to review the information contained in your medical record. If your doctor says you shouldn't see parts of your record, you have the right to have the decision reviewed. The right to review your records extends to your parent or conservator if you are a minor (unless you have admitted yourself to services) and to your legal guardian.

12. You have the right to have your records kept private. You also have the right to be told about the conditions under which information about you can be shared without your permission. You should be aware that your records may be shared with employees of the DSHS system (state facilities and community MHMR centers) who need to see them in order to provide services to you. You should also be aware that your status as a person receiving mental health services may be shared with jail personnel if you are incarcerated.

19. You have the right to be free from unnecessary or excessive medication.

20. You have the right to be told about the care, procedures, and treatment you will be given. You also have the right to be told about the risks, side effects, and benefits of all medications and treatment you will receive, including those that are unusual or experimental, the other treatments that are available, and what may happen if you refuse the treatment.

21. You have the right to meet with the staff responsible for your care and to be told of their disciplines, job titles, and responsibilities. In addition, you have the right to know about any proposed change in the appointment of professional staff responsible for your care.

22. You have the right to request and receive a second opinion from another professional treatment provider at your own expense. You have the right to be granted a review of your treatment plan or a specific procedure by in-house staff.

23. You have the right to be told why you are being transferred to any program within or outside of the agency.

24. You should be notified of your right to appeal a decision by a community MHMR center to deny, terminate, or reduce services or support. If you are a Medicaid recipient, you also have the right to request a Medicaid Fair Hearing.

25. You have the right to receive services that address both psychiatric and substance use disorders.

26. You have the right to appeal a decision made by the MHMR center to deny, terminate or reduce services or support, based on non-payment.

8. You have the right to be informed in writing about any prescription medications ordered by your treating physician, including the name of the medication, the conditions under which it may be prescribed, any risks, benefits, and side-effects and the source of the information provided. This right extends to your family, so long as you agree to it.

9. You have the right to receive a written list of the medication prescribed to you within four (4) hours of requesting it in writing. The list must include the name of each medication, its dosage, how it is given, and how often it is given as well as the name of the doctor who prescribed it. This right extends to your family, with your consent.

10. You have the right to be free from physical restraint and seclusion unless a physician orders it. You may be restrained or secluded in an emergency situation without a physician's order. If the physician does not agree with this decision, you will be released. You must be told why you were restrained or secluded and what you must do to be released.

If you are in an inpatient program, the following rights (11-16) may be limited by your physician, but only on an individual basis in order to maintain your physical and/or emotional well-being or to protect another person. The reasons for any limitation must be written in your medical record, dated, signed by your physician, and fully explained to you and any person legally authorized to represent your interest. Unless otherwise specified, the limit on your rights must be reviewed no less often than every seven- (7) days and if renewed, renewed in writing.

Additional Rights of Persons Admitted to Inpatient Programs

Voluntary Admissions-Special Rights
NOTE: This section does not apply to forensic commitments.

1. You have the right to request your discharge from voluntary admission to a hospital or crisis stabilization unit at any time. You can make this request in writing or by telling a staff person. The staff person must document your request for discharge.

2. By law, you have the right to be discharged from the hospital within four (4) hours after you make a request to be discharged. There are only three reasons why you would not be released:
   - If you change your mind and decide to stay, you can sign a paper that says that you do not wish to leave, or you can tell a staff member that you do not want to leave. The staff member has to write it down for you.
   - If you are under 18 years old and the person who admitted you (your parents, guardian, or conservator) does not want you to leave, you may not be able to leave. If you request your release, staff must explain to you whether or not you can sign yourself out and why. The hospital or crisis stabilization unit must notify the person who has the authority to sign you out and inform them of your request to leave. The doctor or another member of your treatment team must talk to your parent or guardian and document the date, time, and outcome of the conversation in your medical record.
   - You may be detained longer than four (4) hours if a doctor has reason to believe that you might meet the criteria for court-ordered services or emergency detention because:
     - You are likely to cause serious harm to yourself,
     - You are likely to cause serious harm to others, or
     - Your condition will continue to deteriorate and you are unable to make an informed decision as to whether or not to stay for treatment.

Your doctor may consider the option of discharging you if you refuse to consent to treatment.

4. The doctor must document in your medical record and inform you about any plans to file an application for court-ordered treatment or for detaining you for other clinical reasons. If the doctor finds that you are ready to be discharged, you should be discharged without further delay.

5. You have the right to be free from threats or misleading statements about what might happen if you request to be discharged from a voluntary admission to the inpatient program.

Note: The law is written to ensure that people who do not need treatment are not committed. The Texas Health and Safety Code says that any person who intentionally causes or helps another person cause the unjust commitment of a person to a mental hospital is guilty of a crime punishable by a fine of up to $5,000 and/or imprisonment in county jail for up to one year.

Order of Protective Custody – Special Rights

(Admission for up to 14 days)
NOTE: This section does not apply to forensic commitments.

1. You have the right to call a lawyer or to have a lawyer appointed to represent you in a hearing (called a "probable cause hearing") to determine whether you must remain in custody until a hearing on court-ordered mental health services (temporary or extended commitment) is held. The court appointed lawyer represents you at no cost to you.

2. Before a probable cause hearing is held, you have the right to be told in writing:
   - that you have been placed under an order of protective custody,
   - why the order was issued, and
   - the time and place of a hearing to determine whether you must remain in custody until a hearing on court-ordered mental health services can be held. This notice must also be given to your attorney.

3. You have the right to a probable cause hearing within 72 hours of your detention on an order of protective custody, excluding weekends or legal holidays, when the hearing may be delayed until 4:00 in the afternoon on the first regular workday, or in the event of an extreme weather emergency.

4. You have the right to be released from custody if:
   - 72 hours have passed and a hearing has not taken place(except weather emergencies and extension for week-ends and legal holiday),
   - an order for court-ordered mental health services has not been issued within 14 days of the filing of an application (30 days if a delay was granted by the court), or
   - a doctor finds that you no longer need protective custody or court-ordered mental health services.

Consumer Services and Rights Protection

www.dshs.state.tx.us/mhservices/MHConsumerRights.shtm

Stock No. 16-9

12/2007

THE GULF COAST CENTER
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Full Legal Name: _____

Client ID: _____

I acknowledge that I have received a copy of The Gulf Coast Center's Notice of Privacy Practices.

_____ _____
Signature of Individual Receiving Services Date

_____ _____
Signature of Legally Authorized Representative Date

_____
Legally Authorized Representative's Relationship to Individual, if applicable

THE GULF COAST CENTER USE ONLY:

If not signed, describe the efforts to obtain the individual's or legally authorized representative's signature and the reason why the signature was not obtained:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____ _____
Employee Signature Employee # Date

DO NOT PURGE
FILE IN LEGAL/CONSENTS SECTION

GCC #CG2010 (Rev. 3/15)
Copy as needed

Gulf Coast Center
NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Gulf Coast Center (the "Center") and your legal rights regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, that relates to: (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

By signing receipt of privacy practices, you acknowledge assessment information may be shared with other Texas Health and Human Service agencies to screen for other services for which the individual receiving services is eligible. It is understood that opportunity to decline assessment information sharing is provided.

Effective Date: This revised Notice is effective March 26, 2013(rev.). We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by U.S. mail to your last-known address on file and your last e-mail address.

The Center's Responsibilities:

- The law requires us to protect the privacy of your health information. This means that we will not use or let other people see your health information without your permission except in the ways we tell you in this notice. We will safeguard your health information and keep it private. This protection applies to all health information we have about you, no matter when or where you received or sought services. We will not tell anyone if you sought, are receiving, or have ever received services from us, unless the law allows us to disclose that information.
- We will ask you for your written permission (authorization) to use or disclose your health information. There are times when we are allowed to use or disclose your health information without your permission, as explained in this notice. If you give us your permission to use or disclose your health information, you may take it back (revoke it) at any time. If you revoke your permission, we will not be liable for using or disclosing your health information before we knew you revoked your permission. To revoke your permission, send a written statement, signed by you, to the Gulf Coast Center facility where you gave your permission (authorization), providing the date and purpose of the permission and saying that you want to revoke it.
- We are required to give you this notice of our legal duties and privacy practices, and we must do what this notice says. We will ask you to sign an acknowledgement that you have received this notice. We can change the contents of this notice and, if we do, we will have copies of the new notice at our facilities and on our website, www.gcmhmr.com. The new notice will apply to all health information we have, no matter when we got or created the information.

- Our employees must protect the privacy of your health information as part of their jobs. We do not let our employees see your health information unless they need it as part of their jobs. We will punish employees who do not protect the privacy of your health information.
- We will not disclose information about you related to HIV/AIDS without your specific written permission, unless the law allows us to disclose the information.
- **If you are also being treated for alcohol or drug abuse, Gulf Coast Center will not tell any unauthorized person outside of Gulf Coast Center that you have been admitted to Gulf Coast Center or that you are being treated for alcohol or drug abuse, without your written permission. We will not disclose any information identifying you as an alcohol, drug, or substance user, except as allowed by law.**

The Gulf Coast Center may only disclose information about your treatment for alcohol or drug abuse without your permission in the following circumstances:

- Pursuant to a special court order that complies with 42 Code of Federal Regulations Part 2 Subpart E;
- To medical personnel in a medical emergency;
- To qualified personnel for research, audit, or program evaluation;
- To report suspected child abuse or neglect;
- To Advocacy, Inc. and/or the Texas Department of Protective and Regulatory Services, as allowed by law, to investigate a report that you have been abused or have been denied your rights.

Federal and State laws prohibit redisclosure of information about alcohol or drug abuse treatment without your permission.

How We May Use and Disclose Your Protected Health Information: Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We can use or disclose your personal health information to provide, coordinate, or manage health care or related services. This includes providing care to you, consulting with another health care provider about you, and referring you to another health care provider. For example, your personal health information will be shared among members of your treatment team, or with outside entities performing ancillary services relating to your treatment, such as lab work or pharmacy services, or for consultation purposes, or with other agencies involved in provision or coordination of your care.

For Payment. We can use or disclose your personal health information to obtain payment for providing health care to you or to provide benefits to you under a health plan such as the Medicaid program. For example, we may release portions of your personal health information to the Medicaid program and/or a private insurer to get paid for services that we delivered to you.

- **Self-pay/Paying out of pocket.** If you are paying out of pocket for a service, the Center *must* agree to a request to restrict the disclosure of PHI (for payment or health care operations) to your health plan but only if you paid for the service or item in question out of pocket in full.

For Health Care Operations. We can also use your personal health information for health care operations:

- Activities to improve health care, evaluating programs, and developing procedures;
- Case management and care coordination;
- Reviewing the competence, qualifications, performance of health care professionals and others;
- Conducting training programs and resolving internal grievances;
- Conducting accreditation, certification, licensing, or credentialing activities;
- Providing medical review, legal services, or auditing functions; and

- Engaging in business planning and management or general administration.
  For example, we may use your personal health information in evaluating the quality of services provided, or disclose your personal health information to our accountant or attorney for audit purposes.

For Appointment reminders: Unless you provide us with alternative instructions, we may send appointment reminders and other similar materials to your home.

To Business Associates. We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management, but only after the Business Associate enters into a Business Associate agreement with us.

For Fundraising. We may use certain information (name, address, telephone number, dates of service, age and gender) to contact you in the future for fundraising efforts. The money raised by fundraising efforts will be used to expand and improve the services and programs we provide the community. You have the right to opt-out of fundraising activities. If you choose to opt out please write to us at Gulf Coast Center, 4444 West Main, League City, TX 77573 if you wish to have your name removed from the lists to receive fund-raising requests supporting the Center in the future.

For Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you. We may also encourage you to purchase a product or service when we see you. If you are currently an enrollee of a health plan, we may receive payment for communications to you in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care, but only to the extent these communications describe: 1) a provider's participation in the health plan's network, 2) the extent of your covered benefits, or 3) concerning the availability of more cost-effective pharmaceuticals. We will not accept any payment for other marketing communications without your prior written authorization unless you have a chronic and seriously debilitating or life-threatening condition and we are making the communication in conjunction with our provision, coordination, or management of your health care and related services, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. If we make these types of communications to you while you have a chronic and seriously debilitating or life-threatening condition, we will tell you who is paying us, and we will also tell you how to stop these communications if you prefer not to receive them. We will not otherwise use or disclose your medical information for marketing purposes without your written authorization, and we will disclose whether we receive any payments for any marketing activity you authorize.

When required by law. We may use or disclose your health information as required by state or federal law.

To report suspected child abuse or neglect. We may disclose your health information to a government authority if necessary to report abuse or neglect of a child.

To address a serious threat to health or safety. We may use or disclose your health information to medical or law enforcement personnel if you or others are in danger and the information is necessary to prevent physical harm.

For research. We may use or disclose your health information if a research board says it can be used for a research project, or if information identifying you is removed from the health information. Information that identifies you will be kept confidential.

To a government authority if we think that you are a victim of abuse. We may disclose your health information to a person legally authorized to investigate a report that you have been abused or have been denied your rights.

To Advocacy, Inc. We may disclose your health information to Advocacy, Inc., in accordance with federal law, to investigate a complaint by you or on your behalf.

For public health and health oversight activities. We will disclose your health information when we are required to collect information about disease or injury, for public health investigations, or to report vital statistics.

To comply with legal requirements. We may disclose your health information to an employee or agent of a doctor or other professional who is treating you, to comply with statutory, licensing, or accreditation requirements, as long as your information is protected and is not disclosed for any other reason.

For purposes relating to death. If you die, we may disclose health information about you to your personal representative and to coroners or medical examiners to identify you or determine the cause of death.

To a correctional institution. If you are in the custody of a correctional institution, we may disclose your health information to the institution in order to provide health care to you.

For government benefit programs. We may use or disclose your health information as needed to operate a government benefit program, such as Medicaid.

To your legally authorized representative (LAR). We may share your health information with a person appointed by a court to represent your interests.

If you are receiving services for intellectual and developmental disabilities, we may give health information about your current physical and mental condition to your parent, guardian, relative, or friend.

In judicial and administrative proceedings. We may disclose your health information in any criminal or civil proceeding if a court or administrative judge has issued an order or subpoena that requires us to disclose it. Some types of court or administrative proceedings where we may disclose your health information are:

- **Commitment proceedings** for involuntary commitment for court-ordered treatment or services.
- **Court-ordered examinations** for a mental or emotional condition or disorder.
- **Proceedings regarding abuse or neglect** of a resident of an institution.
- **License revocation proceedings** against a doctor or other professional.

To the Secretary of Health and Human Services. We must disclose your health information to the United States Department of Health and Human Services when requested in order to enforce the privacy laws.

Other Disclosures:

Use and Disclosure of Psychotherapy notes. We will only use or disclose your psychotherapy notes if you provide written authorization to do so. "Psychotherapy notes" does not quite mean what you think it would mean; it means private notes of a mental health professional kept separately from the record. A written authorization must be signed by you to release these private notes.

Personal Representatives. We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that: (1) you have been, or may be, subjected to domestic violence, abuse or neglect

by such person; or (2) treating such person as your personal representative could endanger you; and (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights: You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You can look at or get a copy of the health information that we have about you. There are some reasons why we will not let you see or get a copy of your health information, and if we deny your request we will tell you why. You can appeal our decision in some situations. You can choose to get a summary of your health information instead of a copy. If you want a summary or a copy of your health information, you may have to pay a reasonable fee for it.

Right to Amend. You can ask us to correct information in your records if you think the information is wrong. We will not destroy or change our records, but we will add the correct information to your records and make a note in your records that you have provided the information. If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. You can ask us to limit some of the ways we use or share your health information. We will consider your request, but the law does not require us to agree to it. If we do agree, we will put the agreement in writing and follow it, except in case of emergency. We cannot agree to limit the uses or sharing of information that are required by law

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask us to contact you at a different place or in some other way. We will agree to your request as long as it is reasonable.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Complaints: If you believe that Gulf Coast Center has violated your privacy rights, you have the right to file a complaint. You may complain by contacting:

Gulf Coast Center Rights Protection Officer
123 Rosenberg, Suite 6
P.O. Box 2490
Galveston, Texas 77553-2490
(409) 763-2373 or (281) 488-2839

You may also file a complaint with:
TDMHMR Consumer Services and Rights
Protection/Ombudsman Office
(512) 206-5670 (Austin) or (800) 252-8154 (toll free)
P.O. Box 12668
Austin, Texas 78711

U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(800) 368-1019 (toll free)

You must file your complaint within 180 days of when you knew or should have known about the event that you think violated your privacy rights.

You may also contact:
Office of Attorney General
P.O. Box 12548
Austin, Texas 78711
(800) 463-2100 (toll free)
www.oag.state.tx.us

For complaints against alcohol or drug abuse treatment programs, contact the United States Attorney's Office for the judicial district in which the violation occurred. To locate this office, consult the blue pages in your telephone book.

The Gulf Coast Center will not retaliate against you if you file a complaint.

For further information you may contact:

Gulf Coast Center HIPAA Privacy Officer
123 Rosenberg, Suite 6
Galveston, Texas 77553-2490
(409) 763-2373 or (281) 488-2839

The Gulf Coast Center
Child & Adolescent Services Intake Appointment Acknowledgements

Client Name: _____

Client ID# _____ DOB: _____

Regarding intake evaluation appointments for behavioral and/or medication services for Child & Adolescent Services, I understand the following; Please initial each line:

_____If I am unable to be reached to schedule an initial evaluation appointment, my child/adolescent's file will be closed until which time I establish contact with clinic staff to re-initiate process for admittance to services.

_____If I am unable to be reached by clinic staff to make changes to appointment scheduled previously, my child/adolescent's file will be closed until which time I establish contact with clinic staff to re-initiate process for admittance to services.

_____ In order to keep intake evaluation appointment, I must speak to clinic staff Monday morning by 10:00am of the week my child's intake is scheduled. Voicemail reminders and/or voicemail confirmation will not keep appointment date. If required confirmation is not made, appointment will be cancelled until which time I establish contact with clinic staff to re-initiate process for admittance to services.

_____It is my responsibility to provide any change in phone number to GCC clinic staff from date of this screening appointment until intake appointment has been completed.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

GULF COAST CENTER
MENTAL HEALTH • MENTAL RETARDATION
SUBSTANCE USE RECOVERY

Emergency Information Form

My child, _____, has completed the face to face screening/intake appointment at The Gulf Coast Center Child and Adolescent Services. I understand that the clinical staff will review information obtained and that assignment will be made to the appropriate clinician/clinicians, or that referral will be made to another agency.

I understand that in the event of an emergency, i.e., the likelihood of imminent harm to my harm to my child or someone else, I agree to call the Mental Health Deputies, to go to the closest emergency room, or to contact the police. **In an extreme emergency, I will call 911 or my local police first.**

Gulf Coast Center Crisis Hotline **Answered 24 hours a day.**	**1-866-729-3848**
Galveston County Mental Health Deputy	**(409) 766-2300 or** **(409) 766-2323**
Brazoria County Mental Health Deputy	**(281) 331-9000 or** **(979) 864-2392**
The Gulf Coast Center Child & Adolescent Services **Answered 24 hours a day.**	**(409) 935-6083 or** **(281) 474-7376 or** **Toll Free at (877) 226-8780**

Consumer _____ **Date** _____

Guardian _____ **Date** _____

Witness _____ **Date** _____

123 ROSENBERG, SUITE 6
GALVESTON, TEXAS 77550

P.O. BOX 2490
GALVESTON, TEXAS 77553

409.763.2373
FAX 409.763-5538

WWW.GCMHMR.COM

The Gulf Coast Center
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

INFORMATION PERTAINS TO:

CLIENT NAME: _____

CLIENT ID: _____ DATE OF BIRTH: ____ / ____ / ____

I hereby authorize and request:

FACILITY:	Gulf Coast Center Child & Adolescent MH Services
PERSON:	Children's Services
ADDRESS:	3201 FM 2004
CITY/STATE/ZIP:	Texas City, TX 77591
TELEPHONE:	409-944-4600 or 1-877-226-8780
FAX:	409-986-6500

To provide to/receive from: PCP

FACILITY:	Primary Care Physician
PERSON:	PCP Name:
ADDRESS:	
CITY/STATPJZIP	
TELEPHONE:	
FAX:	

Regarding the above referenced medical record from the _____ to _____

The following information, whether written or oral, may be disclosed (check all that apply):

____ ALCOHOL/DRUG(SUBSTANCE) INFORMATION	____ MEDICAL HISTORY AND PHYSICAL EXAM	____ PSYCHIATRIC/PSYCHOLOGICAL EVALUATION/REPORT
____ FINANCIAL RECORDS	____ MEDICATIONS PRESCRIBED	____ SCHOOL RECORDS
____ REV / AIDS I ARC INFORMATION	____ PHYSICIANS ORDERS	____ TRANSFER/DISCHARGE SUMMARY
____ LABORATORY REPORTS	____ PROGRESS NOTES	____ TREATMENT PLANS

____ OTHER: (SPECIFY): _____

Purpose for the Release of Information (check all that apply):

____ ADMISSION INTAKE PLACEMENT TRANSFER	____ DETERMINE ELIGIBILTIY • SOCIAL SECURITY DISABILITY, ETC.	____ PERSONAL USE
____ ASSESS MONITOR TREATMENT NEEDS	____ FINANCIAL/INSURANCE VERIFICATION	____ VERIFICATION OF MAINTAINING
____ CONTINUITY OP CARE MONITOR MEDICAL STATUS	____ LEGAL PROCEEDINGS	APPOINTMENTS

____ OTHER (SPECIFY): _____

I understand that I have the right to refuse this authorization. The Gulf Coast Center will not withhold treatment, Medicaid benefits, or payment processing if I refuse to sign this authorization. However, I will be required to sign this authorization form before being provided treatment if the treatment is alcohol or drug abuse treatment and the purpose of the authorization is to obtain payment for the alcohol and drug abuse treatment; or the treatment is research-related and the purpose of the authorization is to obtain permission to use and disclose protected health information for such research.

I understand that I am entitled to receive a copy of this authorization. I want and have received a copy of such: __Yes No

This consent is valid for a period of no longer than reasonably necessary to serve the purpose for which it is given, in any event not to exceed one year. I understand that the above authorization may be revoked at any time by my written notice, which must be received by The Gulf Coast Center. Revocation will not apply to records already furnished in reliance upon this request.

EXPIRATION DATE: _____ **(UP TO ONE YEAR FROM DATE SIGNED)**

If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult, I understand the information disclosed/used/received may contain information/references to my family or myself.

_____ DATE: _____
SIGNATURE OF CLIENT/LEGALLY AUTHORIZED REPRESENTATIVE

_____
RELATIONSHIP OF LEGALLY AUTHORIZED REPRESENTATIVE TO CLIENT, IF APPLICABLE

_____ DATE: _____
SIGNATURE OF WITNESS (Staff Signature/Title)

_____ DATE: _____
SIGNATURE OF WITNESS* (Staff Signature/Title)

*Two witness signatures are required when an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal as well as state law, Any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis, and/or HIV/AIDS testing and/or diagnosis and treatment of related disorders. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. Ageneral authorization for the release of medical or other information is not sufficient for this purpose.

GCC #9020 (Rev. 3/03)

A photocopy or facsimile of this authorization is as valid as the original.

The Gulf Coast Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PURPOSE: This form must be completed before any client-identifying information is released, with few exceptions as specified by law. This form may be used to release and/or receive written and/or oral information. However, for the release of only VERBAL information, GCC form #9068 "Authorization for Mutual Exchange of Verbal Information" may also be used.

DETAILED INSTRUCTIONS FOR COMPLETION **ROUTING:**

1. Print all information in black ink. Do not use a felt tip pen or pencil.
2. Explain the purpose of this form to the client (or legally authorized representative, if applicable) (i.e., that the form must be completed and signed by the client or legally authorized representative before any written or verbal information may be released, with a few exceptions as specified by law, such as in medical or law enforcement emergencies and other specific circumstances).
3. Explain each section and statement to the client (or legally authorized representative) and ensure that they understand what they are consenting to (or not consenting to) in each section.
4. Print the client's full legal name, social security number, and date of birth (mm/ddlyyyy).
5. Complete the "I hereby authorize:" and "To release to/receive from:" sections.
   " I hereby authorize:" - Identifies the Center program that will be releasing and/or receiving information
   "To release to/receive from:" - Identiifes the facility or individual who is to release and/or receive information
6. Enter the inclusive dates that the information covers.
7. Place a check mark(s) to indicate what information may be released. Check all that apply. Note that alcohol and/or drug (substance) information and/or HIV/AIDS/ARC information may be released ONLY if the applicable blank(s) are checked.
8. Place a check mark(s) by the appropriate statement(s) to indicate the purpose(s) for the release of information.
9. Enter the expiration date (i.e., the date on which the authorization will expire, which can be no later than one year after the consent form is signed).
10. Explain to the client (or legally authorized representative) that they are entitled to receive a copy of the completed authorization form. Check the appropriate blank to indicate if the client received a copy of the completed authorization. (They may not want a copy.)
11. The client (or legally authorized representative) must sign and date the authorization. The consent is invalid if it is not signed and dated.
12. A witness must also sign and date the consent. If the witness is a staff member, he or she should print their title next to their name. If an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark, two witnesses must sign and date the consent.
13. File the completed form in the client's record (permanently). Do not purge. (NOTE: ALL consent forms, regardless of type, shall be retained permanently. Do not destroy any consent form, even if it has expired or has been revoked).
14. To obtain information from another facility or individual, mail a copy of the form to the appropriate address and include a cover letter that brielfy explains why you need the information and where to send the copies.
15. If information is to be released from The Gulf Coast Center, process according to Center policies and procedures.

REVOCATION OF CONSENT: This authorization is not valid if The Gulf Coast Center receives written notice from the client (or legally authorized representative) who signed the applicable authorization. A verbal revocation is not adequate to revoke this authorization. Explain to the client (or legally authorized representative) that The Gulf Coast Center shall not be liable for any consequences resulting from any release of information made prior to The Gulf Coast Center's receipt of written notice of revocation from the client (or legally authorized representative). Upon receipt of a written notice, the notice shall be stamped with the date received, initialed by the staff who received it, and immediately faxed to the Medical Records Administration office at (979) 849-7558 (call the telephone number below to conifrm receipt of the fax). The original revocation shall then be stapled to the applicable authorization and filed in the client's record permanently (do not purge).

FOR ASSISTANCE

SI Please contact Medical Records Administration at (979) 849-2311 or 1-800-710-4322

The Gulf Coast Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

INFORMATION PERTAINS TO:

CLIENT NAME: _____

CLIENT ID: _____ DATE OF BIRTH: ____ / ____ / ____

I hereby authorize and request:

FACILITY:	Gulf Coast Center Child & Adolescent MH Services
PERSON:	Children's Services
ADDRESS:	3201 FM 2004
CITY/STATE/ZIP:	Texas City, TX 77591
TELEPHONE:	409-944-4600 or 1-877-226-8780
FAX:	409-986-6500

To provide to/receive from: School

FACILITY:	School District:
PERSON:	School Name:
ADDRESS:	
CITY/STATP/ZIP	
TELEPHONE:	
FAX:	

Regarding the above referenced medical record from the _____ to _____

The following information, whether written or oral, may be disclosed (check all that apply):

____ ALCOHOL/DRUG (SUBSTANCE) INFORMATION	____ MEDICAL HISTORY AND PHYSICAL EXAM	____ PSYCHIATRIC/PSYCHOLOGICAL EVALUATION/REPORT
____ FINANCIAL RECORDS	____ MEDICATIONS PRESCRIBED	____ SCHOOL RECORDS
____ REV/AIDS I ARC INFORMATION	____ PHYSICIAN'S ORDERS	____ TRANSFER DISCHARGE SUMMARY
____ LABORATORY REPORTS	____ PROGRESS NOTES	____ TREATMENT PLANS

____ OTHER: (SPECIFY): _____

Purpose for the Release of Information (check all that apply):

____ ADMISSION INTAKE PLACEMENT/TRANSFER	____ DETERMINE ELIGIBILTIY • SOCIAL SECURITY DISABILITY, ETC.	____ PERSONAL USE
____ ASSESS MONITOR TREATMENT NEEDS	____ FINANCIAL INSURANCE VERIFICATION	____ VERIFICATION OF MAINTAINING
____ CONTINUITY OP CARE MONITOR MEDICAL STATUS	____ LEGAL PROCEEDINGS	APPOINTMENTS

____ OTHER (SPECIFY): _____

I understand that I have the right to refuse this authorization. The Gulf Coast Center will not withhold treatment, Medicaid benefits, or payment processing if I refuse to sign this authorization. However, I will be required to sign this authorization form before being provided treatment if the treatment is alcohol or drug abuse treatment and the purpose of the authorization is to obtain payment for the alcohol and drug abuse treatment; or the treatment is research-related and the purpose of the authorization is to obtain permission to use and disclose protected health information for such research.

I understand that I am entitled to receive a copy of this authorization. I want and have received a copy of such: __Yes No

This consent is valid for a period of no longer than reasonably necessary to serve the purpose for which it is given, in any event not to exceed one year. I understand that the above authorization may be revoked at any time by my written notice, which must be received by The Gulf Coast Center. Revocation will not apply to records already furnished in reliance upon this request.

EXPIRATION DATE: _____ **(UP TO ONE YEAR FROM DATE SIGNED)**

If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult, I understand the information disclosed/used/received may contain information/references to my family or myself.

_____ DATE: _____
SIGNATURE OF CLIENT/LEGALLY AUTHORIZED REPRESENTATIVE

_____
RELATIONSHIP OF LEGALLY AUTHORIZED REPRESENTATIVE TO CLIENT, IF APPLICABLE

_____ DATE: _____
SIGNATURE OF WITNESS (Staff Signature/Title)

_____ DATE: _____
SIGNATURE OF WITNESS* (Staff Signature/Title)

*Two witness signatures are required when an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal as well as state law, Any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis, and/or HIV/AIDS testing and/or diagnosis and treatment of related disorders. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. Ageneral authorization for the release of medical or other information is not sufficient for this purpose.

GCC #9020 (Rev. 3/03)

A photocopy or facsimile of this authorization is as valid as the original.

The Gulf Coast Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PURPOSE: This form must be completed before any client-identifying information is released, with few exceptions as specified by law. This form may be used to release and/or receive written and/or oral information. However, for the release of only VERBAL information, GCC form #9068 "Authorization for Mutual Exchange of Verbal Information" may also be used.

DETAILED INSTRUCTIONS FOR COMPLETION **ROUTING:**

1. Print all information in black ink. Do not use a felt tip pen or pencil.
2. Explain the purpose of this form to the client (or legally authorized representative, if applicable) (i.e., that the form must be completed and signed by the client or legally authorized representative before any written or verbal information may be released, with a few exceptions as specified by law, such as in medical or law enforcement emergencies and other specific circumstances).
3. Explain each section and statement to the client (or legally authorized representative) and ensure that they understand what they are consenting to (or not consenting to) in each section.
4. Print the client's full legal name, social security number, and date of birth (mm/ddlyyyy).
5. Complete the "I hereby authorize:" and "To release to/receive from:" sections.
   " I hereby authorize:" - Identifies the Center program that will be releasing and/or receiving information
   "To release to/receive from:" - Identiifes the facility or individual who is to release and/or receive information
6. Enter the inclusive dates that the information covers.
7. Place a check mark(s) to indicate what information may be released. Check all that apply. Note that alcohol and/or drug (substance) information and/or HIV/AIDS/ARC information may be released ONLY if the applicable blank(s) are checked.
8. Place a check mark(s) by the appropriate statement(s) to indicate the purpose(s) for the release of information.
9. Enter the expiration date (i.e., the date on which the authorization will expire, which can be no later than one year after the consent form is signed).
10. Explain to the client (or legally authorized representative) that they are entitled to receive a copy of the completed authorization form. Check the appropriate blank to indicate if the client received a copy of the completed authorization. (They may not want a copy.)
11. The client (or legally authorized representative) must sign and date the authorization. The consent is invalid if it is not signed and dated.
12. A witness must also sign and date the consent. If the witness is a staff member, he or she should print their title next to their name. If an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark, two witnesses must sign and date the consent.
13. File the completed form in the client's record (permanently). Do not purge. (NOTE: ALL consent forms, regardless of type, shall be retained permanently. Do not destroy any consent form, even if it has expired or has been revoked).
14. To obtain information from another facility or individual, mail a copy of the form to the appropriate address and include a cover letter that brielfy explains why you need the information and where to send the copies.
15. If information is to be released from The Gulf Coast Center, process according to Center policies and procedures.

REVOCATION OF CONSENT: This authorization is not valid if The Gulf Coast Center receives written notice from the client (or legally authorized representative) who signed the applicable authorization. A verbal revocation is not adequate to revoke this authorization. Explain to the client (or legally authorized representative) that The Gulf Coast Center shall not be liable for any consequences resulting from any release of information made prior to The Gulf Coast Center's receipt of written notice of revocation from the client (or legally authorized representative). Upon receipt of a written notice, the notice shall be stamped with the date received, initialed by the staff who received it, and immediately faxed to the Medical Records Administration office at (979) 849-7558 (call the telephone number below to conifrm receipt of the fax). The original revocation shall then be stapled to the applicable authorization and filed in the client's record permanently (do not purge).

FOR ASSISTANCE

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The Gulf Coast Center
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

INFORMATION PERTAINS TO:

CLIENT NAME: _____

CLIENT ID: _____ DATE OF BIRTH: ____ / ____ / ____

I hereby authorize and request:	
FACILITY:	Gulf Coast Center Child & Adolescent MH Services
PERSON:	Children's Services
ADDRESS:	3201 FM 2004
CITY/STATE/ZIP:	Texas City, TX 77591
TELEPHONE:	409-944-4600 or 1-877-226-8780
FAX:	409-986-6500

To provide to/receive from:	
FACILITY:	
PERSON:	
ADDRESS:	
CITY/STATPJZIP	
TELEPHONE:	
FAX:	

Regarding the above referenced medical record from the _____ to _____

The following information, whether written or oral, may be disclosed (check all that apply):

____ ALCOHOL/DRUG (SUBSTANCE) INFORMATION	____ MEDICAL HISTORY AND PHYSICAL EXAM	____ PSYCHIATRIC/PSYCHOLOGICAL EVALUATION/REPORT
____ FINANCIAL RECORDS	____ MEDICATIONS PRESCRIBED	____ SCHOOL RECORDS
____ REV / AIDS I ARC INFORMATION	____ PHYSICIAN'S ORDERS	____ TRANSFER/DISCHARGE SUMMARY
____ LABORATORY REPORTS	____ PROGRESS NOTES	____ TREATMENT PLANS

____ OTHER: (SPECIFY): _____

Purpose for the Release of Information (check all that apply):

____ ADMISSION INTAKE PLACEMENT/TRANSFER	____ DETERMINE ELIGIBILTIY • SOCIAL SECURITY DISABILITY, ETC.	____ PERSONAL USE
____ ASSESS MONITOR TREATMENT NEEDS	____ FINANCIAL/INSURANCE VERIFICATION	____ VERIFICATION OF MAINTAINING
____ CONTINUITY OP CARE MONITOR MEDICAL STATUS	____ LEGAL PROCEEDINGS	APPOINTMENTS

____ OTHER (SPECIFY): _____

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I understand that I am entitled to receive a copy of this authorization. I want and have received a copy of such: __Yes No

This consent is valid for a period of no longer than reasonably necessary to serve the purpose for which it is given, in any event not to exceed one year. I understand that the above authorization may be revoked at any time by my written notice, which must be received by The Gulf Coast Center. Revocation will not apply to records already furnished in reliance upon this request.

EXPIRATION DATE: _____ **(UP TO ONE YEAR FROM DATE SIGNED)**

If I am signing as a parent/guardian/managing conservator of a minor or guardian of the person of an adult, I understand the information disclosed/used/received may contain information/references to my family or myself.

_____ DATE: _____
SIGNATURE OF CLIENT/LEGALLY AUTHORIZED REPRESENTATIVE

_____
RELATIONSHIP OF LEGALLY AUTHORIZED REPRESENTATIVE TO CLIENT, IF APPLICABLE

_____ DATE: _____
SIGNATURE OF WITNESS (Staff Signature/Title)

_____ DATE: _____
SIGNATURE OF WITNESS* (Staff Signature/Title)

*Two witness signatures are required when an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal as well as state law, Any of the above requested information may include results of alcohol/drug (substance) abuse and/or diagnosis, and/or HIV/AIDS testing and/or diagnosis and treatment of related disorders. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. Ageneral authorization for the release of medical or other information is not sufficient for this purpose.

GCC #9020 (Rev. 3/03)

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The Gulf Coast Center

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

PURPOSE: This form must be completed before any client-identifying information is released, with few exceptions as specified by law. This form may be used to release and/or receive written and/or oral information. However, for the release of only VERBAL information, GCC form #9068 "Authorization for Mutual Exchange of Verbal Information" may also be used.

DETAILED INSTRUCTIONS FOR COMPLETION **ROUTING:**

1. Print all information in black ink. Do not use a felt tip pen or pencil.
2. Explain the purpose of this form to the client (or legally authorized representative, if applicable) (i.e., that the form must be completed and signed by the client or legally authorized representative before any written or verbal information may be released, with a few exceptions as specified by law, such as in medical or law enforcement emergencies and other specific circumstances).
3. Explain each section and statement to the client (or legally authorized representative) and ensure that they understand what they are consenting to (or not consenting to) in each section.
4. Print the client's full legal name, social security number, and date of birth (mm/ddlyyyy).
5. Complete the "I hereby authorize:" and "To release to/receive from:" sections.
   " I hereby authorize:" - Identifies the Center program that will be releasing and/or receiving information
   "To release to/receive from:" - Identiifes the facility or individual who is to release and/or receive information
6. Enter the inclusive dates that the information covers.
7. Place a check mark(s) to indicate what information may be released. Check all that apply. Note that alcohol and/or drug (substance) information and/or HIV/AIDS/ARC information may be released ONLY if the applicable blank(s) are checked.
8. Place a check mark(s) by the appropriate statement(s) to indicate the purpose(s) for the release of information.
9. Enter the expiration date (i.e., the date on which the authorization will expire, which can be no later than one year after the consent form is signed).
10. Explain to the client (or legally authorized representative) that they are entitled to receive a copy of the completed authorization form. Check the appropriate blank to indicate if the client received a copy of the completed authorization. (They may not want a copy.)
11. The client (or legally authorized representative) must sign and date the authorization. The consent is invalid if it is not signed and dated.
12. A witness must also sign and date the consent. If the witness is a staff member, he or she should print their title next to their name. If an individual is his or her own legal guardian and signs his or her name with an "X" or an indescribable mark, two witnesses must sign and date the consent.
13. File the completed form in the client's record (permanently). Do not purge. (NOTE: ALL consent forms, regardless of type, shall be retained permanently. Do not destroy any consent form, even if it has expired or has been revoked).
14. To obtain information from another facility or individual, mail a copy of the form to the appropriate address and include a cover letter that brielfy explains why you need the information and where to send the copies.
15. If information is to be released from The Gulf Coast Center, process according to Center policies and procedures.

REVOCATION OF CONSENT: This authorization is not valid if The Gulf Coast Center receives written notice from the client (or legally authorized representative) who signed the applicable authorization. A verbal revocation is not adequate to revoke this authorization. Explain to the client (or legally authorized representative) that The Gulf Coast Center shall not be liable for any consequences resulting from any release of information made prior to The Gulf Coast Center's receipt of written notice of revocation from the client (or legally authorized representative). Upon receipt of a written notice, the notice shall be stamped with the date received, initialed by the staff who received it, and immediately faxed to the Medical Records Administration office at (979) 849-7558 (call the telephone number below to conifrm receipt of the fax). The original revocation shall then be stapled to the applicable authorization and filed in the client's record permanently (do not purge).

FOR ASSISTANCE

SI Please contact Medical Records Administration at (979) 849-2311 or 1-800-710-4322

The Gulf Coast Center
Same Day Medication Management

Client Name: _____

Client ID# _____ DOB: _____

I hereby understand, acknowledge and accept the following points will be the everyday operation of my child's medication clinic provided by Gulf Coast Center. Please initial each line:

- Medication appointments are now provided on a first-come, first-served approach. Routine appointments are no longer provided. _____
- First-come, first-served, walk-in appointments will be screened to see the doctor during posted days and times only. Individuals presenting too soon for a medication refill, or who are assessed to not require physician contact will see other clinic staff. _____
- Routine medication refills will no longer be provided through telephone contact. Medication refills require your child to be seen by his or her physician. _____
- Priority scheduling is available at the discretion of the physician, and in the event the clinic meets capacity for number of patients to be seen for the day. _____
- Legally Authorized Representative can call ahead the day before, or the day of a scheduled clinic day up to 9:30AM of clinic day, but no more than 24 business hours ahead of time, to be given a time slot for that clinic day. In order to receive a call-ahead time slot, all chart related paperwork must be up-to-date. Caller must speak directly with Financial Team Leader or designee to receive a timeslot. Phone messages/voice messages will not be accepted to receive a call-ahead time slot. _____
- Same Day Medication Clinic will be cancelled in the event the physician assigned calls in sick, or is unable to present for some other identified reason. In the event the center cancels clinic, every effort will be made to provide refills of all non-stimulant medication by the corresponding county Child & Adolescent Gulf Coast Center doctor. Stimulants will not be refilled until the treating physician returns. Patients will be asked to return to the next first-come, first- served scheduled clinic required unless there is an assessed medical need by staff for a priority scheduled appointment. _____

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

GULF COAST CENTER
PERMISSION TO REPRESENT PARENT/GUARDIAN

Client's Full Legal Name: _____

Client ID (ECET) Number: _____ Date of Birth: _____

I, _____ do hereby designate
Printed Name of Parent/Guardian

_____ to serve as legally authorized representative in my absence.
Printed Name of Designated Representative

By initialing the blanks below, I authorize my consent for the individual designated above to participate in treatment as follows:

I understand failure to provide consent for the designated representative to make decisions regarding medications will obligate me as the Legally Authorized Representative to attend the medication management appointment. _____

_____ Make decisions regarding changes to medication.

_____ To complete and sign documents as needed, including:

- _____ Consents for new medication
- _____ Completion of the required assessments including the CANS
- _____ Consents to provide treatment
- _____ Completion of Treatment Plans & Treatment Plan Reviews
- _____ Consents to release/obtain information

_____ To represent the guardian by participating in treatment through communication and collaboration with staff members.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Designated Representative Date

_____ _____
Signature of Staff Date

Revoke of Permission to Represent

(Do not complete until Revoke or Cancellation of Permission to Represent has been requested. Must be signed by LAR before it is effective.)

I, _____, hereby revoke this authorization for permission to represent effective _____ (date).

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Staff Date

The Gulf Coast Center and NAMI Gulf Coast Referral Form

The Gulf Coast Center works in concert with the NAMI Gulf Coast in facilitating consumers and their families with accessing additional beneficial services to individuals served. NAMI Gulf Coast is contracted to:

1. Provide family education and training services, including but not limited to consultation with, orientation for, and information provided to families regarding the nature and consequences of, and treatment options for, severe and persistent mental illness, designed to increase family coping skills.
2. To provide family support by having care and share group meetings in both Galveston and Brazoria Counties.
3. To provide family support by having care and share group meeting in both Galveston and Brazoria Counties.
4. To provide family and/or consumer information and referral services including crisis information.
5. To maintain and operate a consumer furniture bank to assist those in need of items.
6. To provide community and public education for governmental assistance entities.
7. To provide financial assistance to consumers, when necessary and available.
8. To provide Vision for Tomorrow education for families with young children.

The center requests your permission to fax this referral form to the NAMI Gulf Coast so you may be contacted to explore services which may be of assistance to you and/or your family member(s).

_____ I do **not** wish to have my contact information sent to NAMI Gulf Coast at this time.

_____ _____

Parent/Legally Authorized Representative Signature Date

****

Please complete the following if you wish to be contacted:

Youth Name: _____ LAR Name: _____

Phone: _____ Address: _____ City _____ Zip Code _____

County of Residence: _____ Age: _____ Email: _____

Type of Service: **Adult MH** or Child **MH**

Caregiver Statistics Needed:

- Age group: ___0-6yrs ___7-18yrs ___19-34yrs ___35-54yrs ___55-70yrs ___71+yrs
- Sex: ___Male ___Female ___Other
- Ethnicity/Race(Select all that apply): ___Caucasian ___African American ___Hispanic ___Native American ___Asian American/ Pacific Islander ___Other
- Income Source: ___Employed ___Unemployed ___Social Security ___Student ___Public Assistance(SNAP/TANF and/or housing) ___Retired ___Homemaker
- Location ☐ Brazoria ☐ Galveston County ☐ Fort Bend County
- (County of Residence): ☐ Harris County ☐ Matagorda County ☐ Other_____

_____ _____

Youth Signature Date

_____ _____

Parent/Legally Authorized Representative Signature Date