Notice of Client Rights

Center for Family & Maternal Wellness, we respect and amplify the inherent dignity and human rights of all people. The following are common rights relative to receiving care at CFMW:

1. Clients must be placed in the least restrictive environment. This environment should be capable of N meeting their physical, social, emotional, and cultural needs.
2. Clients will not be abused, exploited, neglected, or otherwise harmed and will be free of humiliation and any form of retaliation.
3. Each client has the right to an individual service plan involving an adequate number of competent, qualified, and experienced staff. Staff members shall carry out their duties in a manner that preserves and enhances the client's and family's dignity and privacy, insofar as the plan of care allows. When possible, the client and family shall be encouraged to participate in setting goals for the service the client receives.
4. Each client has the right to the purpose and goals of his/her treatment and nature of treatment procedures that shall be employed to obtain these goals.
5. Each client and family has the right to a description of the risks, side effects and benefits of medication, if any, which may be administered to the client as part of the treatment program, and the right to refuse specific medication to the extent permitted by law.
6. Clients have the right and responsibility to understand the challenges, illness and treatment associated with his/her disability.
7. Clients have the right to receive services that provides the most freedom possible towards being an independent person and having the life one desires.
8. Clients have rights to confidentiality, to make advance instructions, and to be treated with respect.
9. Clients have the right to be treated with respect regardless of their gender, gender identity, sexual orientation, gender expression, and sexuality.
10. Clients have the right to be referred to by the gender pronounces consistent with their gender identity.
11. Clients have the right to understand the cost of services.
12. Each client has a right to understand how to file a grievance when his rights have been violated
13. Clients have the right to receive appropriate educational services.
14. Clients have the right to make religious, spiritual, and other decisions that are culturally desirable and such preferences being responded to as reasonably possible.
15. Clients have the right to treatment, including access to medical care and habilitation, regardless or age or degree of mental illness, developmental disabilities, or substance abuse.

As a consumer and/or legal guardian I am aware and fully understand my client rights. If you or your child feel that CFMW is in violation of any of the aforementioned client rights please feel free to contact: Disability Rights NC-(919) 856-2195

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Confidentiality Agreement Form

I understand that sensitive information may be obtained regarding my treatment through the Center for Family & Maternal Wellness. Such information may contain, but is not limited to, service notes, treatment records, medical and psychological diagnoses, school records, financial records, and client psychosocial and medical histories. All such information is considered to be strictly confidential, regardless of the form in which it is maintained or transmitted (to include, but is not limited to, information obtained verbally, electronically, stored on audio or video tapes, in client records, on computer files or computer networks, etc.). While being treated at the Center for Family & Maternal Wellness, I understand that any information related to my treatment shall be strictly confidential.

While receiving treatment through the Center for Family & Maternal Wellness I understand that:

A. Information concerning clients of the Center for Family & Maternal Wellness is strictly confidential and shall be used only in accordance with privacy and confidentiality guidelines.
B. Information related to clients, or the Center for Family & Maternal Wellness without express written permission shall not be released.
C. All confidential information related to clients and the Center for Family & Maternal Wellness shall be maintained in a secure place.
D. All information related to clients and the Center for Family & Maternal Wellness is confidential, even in situations where an employee's association with the Center for Family & Maternal Wellness has ended.
E. In the event an employee of the Center for Family & Maternal Wellness is terminated (for whatever reason) she/he agrees to immediately return all information and equipment that may be in his/her possession to the Center for Family & Maternal Wellness.

As a consumer and/or legal guardian, I understand that any information regarding my treatment is confidential and shall not be released without my written permission unless legal actions dictates the release of specific information and/or information is required to be released in an emergency situation to ensure my the health and safety.

_____ _____

Parent/ Legal Guardian Signature Date

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

Consent to Receive Treatment

I, _____, have discussed with the staff of the Center for Family & Maternal Wellness the following indicated/requested services:

____ Assessment
____ Family Therapy
____ Outpatient Therapy
____ Substance Abuse Counseling
____ Diagnostic Assessment
____ Relationship Counseling
____ Other _____

As a client, I further understand that I shall be treated with respect to the basic rights of dignity, privacy and humane care and retain the right to:

- Be informed of the qualifications of professionals rendering services.
- Approve the release of confidential information about myself.
- Receive an individualized, written service plan which includes the anticipated goals, as well as services to be provided in order to achieve those goals.
- File a formal grievance, if necessary, against employees, interns or any associate providing services for the Center for Family & Maternal Wellness. If I need assistance filing such grievance, I understand the Center for Family & Maternal Wellness Program Director or designee will assist me with this process.
- To contact The Governor's Academy Council at any time at (800) 821-6922.
- To be made aware of the rules I am expected to honor.
- To have reasonable access to a telephone and postage for letters.
- To receive service free of humiliation, discrimination, exploitation and abuse or neglect.

My signature below reflects my understanding of my rights, my consent of such services and my full participation and freedom of choice in the treatment planning process. I also understand if any additional services not already indicated may be recommended, I will have further opportunity to participate in the planning of such additional services. I understand I can withdraw my consent at any time unless I have been ordered to receive such services by Court Order.

_____ _____
Parent/Legal Guardian Signature Date

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

Abuse and Neglect Policy for Consumer Understanding

Specific statutes are in place to help prevent abuse and neglect. The following are outlined below:

N.S.G.S. 14-318.2 Child abuse is a general misdemeanor. (A) Any parent of a child less than 16 years of age, or any, person providing care or supervision of such a child, who inflicts physical injury, or who allows physical injury to be inflicted or creates or allow to be created substantial risk of physical injury, upon or to such child by other than accidental means I guilty of the Class A1 misdemeanor of child abuse. (b) The Class A1 misdemeanor of child abuse is an offense additional to other civil and criminal provisions and is not intended to repeal or preclude any other sanctions or remedies and punishable as provided in G.S. 14-3 (a).

N.C.G.S 14-3 Punishment of misdemeanors, infamous offences, and offenses committed in secrecy and malice or with deceit and intent to defraud. (A) Except as provided in subsection (B), every person who shall be convicted of any misdemeanor for which no specific punishment is prescribed by statute shall be punishable by fine, by imprisonment for a term not exceeding two years, or by both, in the discretion of the court.

Employees and of the Center for Family & Maternal Wellness are responsible for reporting abuse/neglect/humiliation/ exploitation/retaliation or suspected abuse or neglect. A report must be filed with the County Child Protective Services or Adult Protective Service. If the report of Abuse/Neglect/ Humiliation or Exploitation concerns a client of the Center for Family & Maternal Wellness staff are responsible for immediately notifying the Center for Family & Maternal Wellness Program Director or designee. The Program Director is then responsible for immediately notifying the client's Area Mental Health Case Manager (if applicable) to inform of the suspected Abuse/Neglect/Humiliation/Retaliation or Exploitation. Examples of Abuse, Neglect, Humiliation or Exploitation are listed below and will not be tolerated.

The Center for Family & Maternal Wellness ensures that appropriate measures are taken to make certain that the consumer is protected from physical, sexual, psychological, and fiduciary abuse; harassment and humiliating, threatening, or exploiting actions. As a consumer of the Center for Family & Maternal Wellness, my signature indicates my understanding of the agency's policies surrounding abuse, neglect, humiliation, retaliation and exploitation and further indicates that I have received a copy of this form.

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

Client Signature Date

_____ _____

Witness Signature Date

EMERGENCY CONTACT FORM

I _____, (consumer) and _____ (legal guardian), give the Center for Family & Maternal Wellness and the providers of the Center for Family & Maternal Wellness permission to access the following contacts in case of emergency and to provide medical attention necessary to myself and/or my child.

I have a Health Care Power of Attorney Yes ☐No ☐(If yes put supporting documentation with PCP or treatment plan)

I would like information on getting a Health Care Power of Attorney Yes ☐ No☐(Assist consumer/family as needed)

Emergency Contact Person(s)

Name: _____ Relationship: _____
Address: _____
_____
Phone #: (H) _____ (W)_____

Name: _____ Relationship: _____
Address: _____
_____
_____
Phone #: (H) _____ (W)_____

Emergency Medical

Preferred Physician:
Name: _____
Address: _____
_____
Phone #: _____

Additional Emergency Medical _____
_____
_____

My signature below indicated that I grant the Center for Family & Maternal Wellness permission to contact the above named individuals in case of an emergency, sudden illness or accident. I further grant permission for the Center for Family & Maternal Wellness to seek emergency care for me/my child (circle one) from Emergency Services, a hospital, or a physician.

Legal Guardian Signature: _____ Date: _____

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

General Overview of The Privacy Rule

Every time a patient sees a doctor or healthcare related person, a record is made of that person's confidential health information. In the past, these records were physically sealed away in offices and file cabinets. In an attempt to save the health care industry money, HIPAA was enacted which encouraged electronic transactions. Consequently, new safeguards were required to protect the security and confidentiality of personal health information, as private information was no longer simply locked in a file cabinet. These safeguards are referred to as the Privacy Rule. The HIPAA federal regulation created national standards to protect individuals' personal health information, and gives patients increased access to their own medical records.

Protected health information is any and all individually identifiable health information (information that can be linked to a client) that is transmitted or maintained by a health care provider regardless of the form of that information (i.e. oral, written, audio tape, video tape, computerized, etc.) This information includes, but is not limited to, an individual's past, present, and future health, health care, payment for health care, including demographic data, medical and psychological diagnoses and histories, medications, school records, financial records, etc.

There are five basic principles outlined in the Privacy Rule:

- It gives patients more control over their health information
- It sets boundaries on the use and release of health records
- It establishes appropriate safeguards that health care providers and others must achieve to protect the privacy of health information.
- It holds violators accountable with civil and criminal penalties that can be imposed if they violate patients' privacy rights.
- It strikes a balance when public responsibility requires disclosure of some forms of date – for example, to protect public health.

What does this mean for everyday practice?

In many ways, it is business as usual for the Center for Family & Maternal Wellness' service providers. It requires that we:

- Obtain written authorization to release information about clients to other health professionals, or parties involved with a client's wellbeing.
- Provide clients with written information (Notice of Privacy Practices) on their privacy rights and how their information may potentially be used.
- Be more conscientious of incidental use and disclosure of our client's personal information (i.e. talking about clients personal information in a manner that cannot be overheard by others, ensuring that client information is kept secure in the home, that computers have passwords so that unintended users do not gain access to client information).
- Ensure that when disclosure is appropriate and authorized, that information be limited to the amount of information reasonable necessary to accomplish the purpose for which disclosure is sought – i.e. do not provide more information than is necessary for the situation.
- Ensure that staff access to private information is limited to what is necessary to perform their specific job responsibilities.
- Minimize access to information by locking confidential files in filing cabinets in locked record rooms, and by creating passwords on computers that maintain personal information.
- Limit personal use and respecting the ownership of computers/software and other property of the Center for Family & Maternal Wellness.
- The Privacy Rule also has many guidelines for electronic transactions and code set standards, as well as guidelines for marketing, fundraising, research, and other activities in which CFMW does not participate.

My signature below reflects my understanding of HIPAA as it relates to privacy and further indicates that I have received a copy of this signed consent.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practices

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

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

As a social worker licensed in this state and as a member of the National Association of Social Workers, it is our practice to adhere to more stringent privacy requirements for disclosures without an authorization. The following language addresses these categories to the extent consistent with the *NASW Code of Ethics* and HIPAA.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at (704) 659-4997:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at (704) 659-4997, the Secretary of the North Carolina Department of Health and Human Services (DHHS) at 101 Blair Dr, Raleigh, NC 27603 or by calling (800) 662-7030, or with Disability Rights NC- (919) 856-2195. **Center for Family & Maternal Wellness will not retaliate against you for filing a complaint.**

The effective date of this Notice is March 2016.

☐ **I have received a copy of Center for Family & Maternal Wellness Privacy Policy**

_____ _____

Consumer Signature Date

_____ _____

Witness Signature Date

Center for Family & Maternal Wellness
Freedom. Growth. Development. Healing.

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: _Community Mental Health Center_____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: __704-449-2664____

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care_____

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

Center for Family & Maternal Wellness
Freedom. Growth. Development. Healing.

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: County Court

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: **Center for Family & Maternal Wellness** Phone: 704-449-2664

Information to be released: ☐ Verbally ☐ In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: coordination of care

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: __Emergency Provider_____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: __704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care_____

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1-State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: _____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: 704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care _____

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

Center for Family & Maternal Wellness
Freedom. Growth. Development. Healing.

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: Out Patient Therapist _____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: ___**Center for Family & Maternal Wellness**_____ Phone: __704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care _____

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:** 0

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: Primary Care Physician_____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: 704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care _____

This consent shall be valid until: _____
(Date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1-State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

Center for Family & Maternal Wellness
Freedom. Growth. Development. Healing.

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: Psychiatrist _____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: 704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care _____

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director of Family Services. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release.

Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

AUTHORIZATION TO RELEASE INFORMATION

Client Name: **Date:**

I authorize Center for Family & Maternal Wellness to release information reciprocal to and from:

Title/Designee: _____

Address: _____
(street) (city) (state) (zip code)

Agency Receiving Info: _**Center for Family & Maternal Wellness**_ Phone: 704-449-2664

Information to be released: ☐Verbally ☐In Writing ☐ By Fax

Specific Information to be released (Do not pre-print):

_____

_____

Specific Purpose: _____coordination of care _____
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Parent/Legal Guardian Signature _____ Date _____

Consumer Signature _____ Date _____

Witness Signature _____ Date _____

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HEALTH HISTORY QUESTIONNAIRE

	History/ Current		History/ Current	What treatment Received and Date(s)
Anemia	☐H ☐C	Oral Health/Dental	☐H ☐C	
Allergies	☐H ☐C	Stomach/ Bowel Problems	☐H ☐C	
Asthma	☐H ☐C	Stroke	☐H ☐C	
Bleeding Disorder	☐H ☐C	Thyroid	☐H ☐C	
Blood Pressure	☐H ☐C	TB	☐H ☐C	
Bone Problems	☐H ☐C	Aids/HIV	☐H ☐C	
Cancer	☐H ☐C	Sexual Transmitted Disease	☐H ☐C	
Cirrhosis of the liver	☐H ☐C	Learning Problems	☐H ☐C	
Diabetes	☐H ☐C	Speech Problems	☐H ☐C	
Epilepsy/ Seizures	☐H ☐C	Anxiety	☐H ☐C	
Eye Disease/ Blindness	☐H ☐C	Bipolar	☐H ☐C	
Fibromyalgia/Muscle pain	☐H ☐C	Depression	☐H ☐C	
Glaucoma	☐H ☐C	Eating Disorder	☐H ☐C	
Headaches	☐H ☐C	Hyperactivity/ ADD	☐H ☐C	
Head Injury/ Brain Tumor	☐H ☐C	Schizophrenia	☐H ☐C	
Hearing problem/ Deafness	☐H ☐C	Sexual Problems	☐H ☐C	
Heart Disease	☐H ☐C	Sleep Disorders	☐H ☐C	
Hepatitis/ Jaundice	☐H ☐C	Suicide Attempts/ thoughts	☐H ☐C	
Kidney Disease	☐H ☐C	Other	☐H ☐C	

Has client had medical hospitalization/surgical procedures in the last 3 years?

☐ No ☐Yes If yes, completed information below

Hospital	City	Date	Reason

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☐ None ALLERGIES/DRUG SENSATIVITIES

☐ Food (specify)

☐ Medicine (specify)

☐ Other (specify)

☐ Not Applicable PREGNANCY HISTORY

Currently pregnant? If yes, expected due date ☐No ☐Yes, Due Date:	Receiving pre-natal healthcare? If yes, indicate provider ☐ No ☐Yes, Provider Name:
Last Menstrual Period Date:	Any significant pregnancy history? If yes, explain ☐No ☐ Yes

LAST PHYSICAL EXAMINATION

By Whom:	Date:	Phone No. (If known)

HAS CLIENT HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 60 DAYS? Please Check

☐Ankle swelling	☐Coughing	☐Lightheadedness	☐Penile Discharge	☐Urination Difficulty
☐Bedwetting	☐Cramps	☐Memory Problems	☐Pulse Irregularity	☐Vaginal Discharge
☐Blood in stool	☐Diarrhea	☐ Mole/Wart changes	☐Seizures	☐Vision Changes
☐Breathing Difficulty	☐Dizziness	☐Muscle Weariness	☐Shakiness	☐Vomiting
☐Chest Pain	☐Fainting	☐Nervousness	☐Sleep problems	☐Constipation
☐Confusion	☐Gait unsteadiness	☐Nose bleeds	☐Sweats (night)	☐Hearing Loss
☐Consciousness Loss	☐Hair change	☐Numbness	☐Tingling in Arms & Legs	
☐Panic Attacks	☐Tremors	☐Other: _____		

Immunizations (Required for Child or MR/DD only)

Immunizations – Has client had or been immunized for the following diseases? Please Check

☐Chicken Pox ☐Diphtheria ☐German Measles ☐Hepatitis B ☐Measles

☐Mumps ☐Polio ☐Small Pox ☐Tetanus ☐Other: _____

Immunizations with the Past Year:

HEIGHT/WEIGHT

Height:	If reporting for a child, has height changed in the past year? ☐No ☐Yes If yes, by how much? (+, -)?
Weight:	Has client's weight changed in the past year? ☐ No ☐Yes If yes, by how much (+, -)

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Client Tuberculosis (TB) Screening:

Date: _____

Client Name: _____ DOB: _____

Symptoms (Check all that apply):

- ☐ Fatigue
- ☐ Low grade fever
- ☐ Loss of apeptite
- ☐ Persistant Diarrhea
- ☐ Shortness of breath
- ☐ Presistent cough
- ☐ Has lived with a sympotmatic person
- ☐ Cutrently lives with a symptomatic person
- ☐ Lumps or swollen glands
- ☐ Night sweats
- ☐ Weight loss
- ☐ Pain in spine or large joints
- ☐ Pain with breathing
- ☐ Cough with discolored or bloody sputum
- ☐ Client reports no symptoms

Have you ever had a positive TB test? ☐YES ☐NO on date: _____

Based on the consumer's reponses above, AFS is providing the following action/recommendations to promote the client health and well being. A release should be secured and the screening copied to the client/guardian to take with them as applicable and referred.

☐ No action is needed on the client/guardian responses

☐ Referred to the county health department:
_____

☐ Referred to the client's primary health care physician:
_____

☐ Referred to the area emergency facility:
_____

Notes: _____

_____

Clinician/Clinical Supervisor: _____ Date: _____