McLAREN FLINT
BEHAVIORAL HEATH CENTER

RECIPIENT RIGHTS – CONSENT TO TREATMENT – CLIENT CONFIDENTIALITY

I have received the brochure, "A Summary of Your Rights". I understand that I have rights as a recipient of service, including confidentiality of my records, and I can get more information about my rights from my Program Recipient Rights Advisor.

I consent to mental health treatment and/or substance abuse treatment as recommended by the psychiatrist/therapist. I understand I will participate in the development of my treatment plan and that I am free to withdraw my consent and discontinue treatment at any time within the guidelines outlined in the brochure.

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this program. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser, UNLESS:

1. The patient consents in writing;
2. The disclosure is allowed by a court order; or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program, or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local authorities.

I have read this agreement. I had the opportunity to ask questions which have been answered to my satisfaction. I understand and agree to the conditions specified herein and have been given a copy of this signed agreement.

_____ _____ / _____ / _____
Client's Signature Date

_____ _____ / _____ / _____
Therapist's Signature Date

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MR.#/P.M.

DR.