McLaren
NORTHERN MICHIGAN

BEHAVIORAL HEALTH
PATIENT CONFIDENTIALITY CONSENT

I understand that information relating to my presence at McLaren-Northern Michigan Region, Behavioral Health Unit will not be made known to anyone not authorized by the Mental Health Code (MCLA 330.1748) without my permission.

Relatives, friends and others often call to ask about patients while they are in the hospital. I authorize the staff to acknowledge my presence in the Behavioral Health Unit to the persons who may call:

I also recognize that many times it is important for family members and or significant others to become involved with treatment issues and/or concerns. I authorize the Behavioral Health Unit staff to provide to and receive from my family or significant other information to facilitate treatment while I am a mental health recipient.

I am willing to have visitors while a patient in the Behavioral Health Unit with the exception of the following persons:

The person(s) I wish to be notified in an emergency or significant change in status are:

MEDICAID OR MEDICAID ELIGIBLE INPATIENTS:
I understand that my local Community Mental Health Agency will be notified of my admission in order to comply with mandated Medicaid reporting requirements.

SIGNATURE OF PATIENT	DATE SIGNED	SIGNATURE OF WITNESS	DATE SIGNED
X		X	

ADDRESSOGRAPH

720B

BEHAVIORAL HEALTH
PATIENT CONFIDENTIALITY CONSENT